DOCTORAL THESIS

A qualitative investigation into therapists' perceptions on what factors facilitate abstinence in clients who self-identify as being sexually attracted to children

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A qualitative investigation into therapists' perceptions on what factors facilitate abstinence in clients who self-identify as being sexually attracted to children

by

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Abstract

This research explored the construction of helpful and hindering factors impacting an individual's ability to abstain from acting on their sexual attraction to children (under the age of 16), through the eyes of their psychologist/psychotherapist. In an attempt to distinguish this client group from convicted sexual offenders or child pornography users, clinicians who had only worked with these clients group were excluded from the research, placing a sole focus on paedophiles/hebephiles who had not used the Internet or contact means to act on their sexual attraction to children. Using Constructivist Grounded Theory four categories emerged set within a sphere of client's feeling as if they were suspended in "no-man's land". Category one, 'stepping out from the shadows', reflects the negotiation of disclosing a sexual attraction to children. The second category, 'driving them underground', demonstrated the societal push for paedophiles/hebephiles to retreat from society. The third category, 'victims of bureaucracy', reflected the required negotiation of bureaucracy from both the client and clinician. The final category, 'therapy: the glue that holds everything together', accounted for the perceived impact of therapy in the management of a sexual attraction to children. The final framework suggests that factors that could aid abstinence in individuals who are sexually attracted to children are constructed within a sphere of hope, facilitating their acquisition of social existence and their fight to belong in treatment services. The final framework draws attention to the role and impact of clinicians through the adherence to ethical guidelines, legal principles and the need for training programmes to engage with this difficult to think about client group.

Contents

Glossary

BABCP – British Association for Behavioural & Cognitive Psychotherapies

BACP – British Association for Counselling & Psychotherapy

BPS – The British Psychological Society

COSRT – College of Sexual and Relationship Therapists

CSA – Child sexual abuse

CSO – Child sex offender

GLM – Good Lives Model (Ward & Brown, 2004)

GT – Grounded Theory

HCPC – Health and Care Professionals Council

ISO – Internet sex offender

LFF – Lucy Faithfull Foundation

PPD – Project Prevention Dunkelfeld (Germany)

SO – Sex offender

UKCP – UK Council for Psychotherapy

Chapter I: Introduction

The aim of this chapter is to locate the necessity of this research within the field of Counselling Psychology, exploring the rationale for encroaching on a subject matter monopolised within the forensic field, bringing the treatment of sexual attraction to children into the arena of community and private practice services. The present research adopts the use of terms that have been hotly debated and contested within psychology and the British media. Over the course of this chapter the definitions and rationales for using each term will be explored and explained.

1.1 Definitions

1.1.1 "Sex Offender" (SO)

"Paedo", "child molester", "kiddie-fiddler", "nonce" and "pervert" are all terms that have been used interchangeably within the British press to represent one group of individuals: those who have engaged in a sexual activity with a child. It has led to much debate over the correct terminology to be used, and what each term represents. Despite social preference, each term can be related to one overarching umbrella term of "sex offender". The term SO is far reaching within UK law and can apply to individual's committing acts against adults, animals, children and/or corpses, or conducting a sexual activity in a public lavatory (Sexual Offences Act, 2003). Thus it is confusing as to what being a "SO" actually constitutes, with the severity of the prison term dependent upon the

offence committed. For the purpose of the present research this term will be clarified and provided with a specific meaning.

Currently in UK legislation there is over twenty specific sexual offences[1] that involve the use of children (SOA, 2003). These range from the "rape of a child under 13" (S5, ibid) to "controlling a child prostitute or a child involved in pornography" (S49, ibid), by committing any of these offences an individual is breaking UK law and will be charged as a SO. Acts such as exposure and grooming, which are more generic in label, can also be applied to both adult or child victims increasing the number of sexual offences that could include the presence of a child. The present research will focus on one small subsection of the SO population that psychological professionals are working with: individuals who commit a physical sexual act involving the use of a child. This corresponds to seven divisions within the SOA 2003[2]. Specifically, the present research will focus on what helps or hinders abstinence in adult clients (over the age of 18) who have never (as best to their therapists knowledge) acted on their sexual attraction to children and young adults (under the age of 16) either physically or via the use of the Internet.

The SOA 2003 also makes distinctions between children under 13, and individuals classified as 'youth' (children under 16). As 16 is the legal age of sexual consent within the UK, the present research will use this as the distinguishing age for determining whether an attraction is being held towards

[1] Please refer to Appendix 1 (pg.207) for the full list of sexual offences involving the use of a child.

[2] Please refer to Appendix 2 (pg.208) for the seven specific offences corresponding to the present research.

an adult or child. In this research, the term 'SO' will refer to individuals who have conducted sexual activity with a child under the age of 16. The term "child/children" will be used to represent the sample of potential victims. Therefore, within the present research 'being sexually attracted to children' is defined as an adult, over the age of 18, being sexually attracted to an individual who is *under* the age of 16. The present research is opting to combine paedophilia and hebephilia and the SOA 2003 use of child and youth.

1.1.2 "Paedophilia" / "Hebephilia"

1.1.2.1 Paedophilia

The term 'paedophile' is now commonplace within UK; however, the definition is often blurry with members of the public and psychological professionals having different interpretations. Within the UK Criminal Justice System the use of the term "paedophile" or "paedophilia" does not exist. Thus, whilst UK society believes an individual has been arrested and/or charged for being a paedophile, *legally* the individual has been charged under the terminology of "SO". Paedophilia is a medical term[3], coming under the umbrella of paraphilias, which is defined as a disorder of an individual's sexual intention (Levine *et al.,* 1990). The classification of paraphilias is often problematic due to changing societal norms, and legal standings, resulting in some paraphilias being classed as legal (fetishism and sadomasochism) whilst others are classed as illegal (paedophilia).

[3] For full DSM-V and ICD-10 diagnostic criteria for paedophilia please refer to Appendix 16, pg.231.

1.1.2.2 Hebephilia

Hebephilia is defined as an individual having a preferred sexual preference for children who have entered puberty (Blanchard & Barbaree, 2005; Blanchard *et al.,* 2009; Schaefer *et al.,* 2010). Over the past decade a growing body of research has called for hebephilia to be classified as a distinct paraphilia (Blanchard *et al.,* 2009), with specific calls being made for it to have been listed within DSM-V (APA, 2013) and ICD-10 (WHO, 1993) to no avail. Psychological professionals have contested hebephilia as a medical concept, with many arguing that hebephilia is not a mental health disorder but rather a crime (Frances, 2011). This on-going debate provides added difficulty in the classification of individual's who align as having a sexual attraction to pubescent children who are still under the age of sexual consent, as well as difficulty in determining whether psychological treatment or custodial sentences are best suited when considering this population. This debate is outside of the scope of the present research.

1.1.3 Internet Sex Offenders (ISO)

Since the launch of the Internet a distinct category of SO has gained in prevalence and attention by researchers, explicitly, those who use the Internet in order to sexually offend (Merdian *et al.,* 2011). It is estimated that over 2000 individuals are arrested each year in the UK for the possession (and potentially making/distributing) of indecent images of children (Merdian & Perkins, 2014). Furthermore, statistics released by the Crown Prosecution Service in 2014

displayed the commencement of 20,373 prosecutions in relation to child abuse image offences (Merdian *et al.,* 2016). Within current UK legislation an indecent image refers to any still, moving or pseudo-photographs in which children are depicted as being sexually abused or exploited (McGuire & Dowling, 2013). Two forms are online grooming and the proliferation of indecent images of children. Online grooming is defined as the "use of digital technology to facilitate either online or offline sexual contact with minors" (McGuire & Dowling, 2013 pg.4). The proliferation of indecent images of children "incorporates the use of digital technologies to produce, distribute or possess offensive or indecent images of children" (McGuire & Dowling, 2013 pg.4). Interpol has defined child pornography as, *"any means of depicting of promoting the sexual exploitation of a child, including written or audio material, which focus on the child's sexual behaviour or genitals"* (Gillespie, 2009 pg. 6).

Other than child pornography the sexual exploitation of children via the Internet can occur in numerous ways (see: Beech, Elliott, Birgden & Findlater, 2008; Taylor & Quayle, 2003). For example: engaging with likeminded individuals who hold a sexual attraction to children, to engage in inappropriate sexual communication with children, to harass children with sexually explicit material, to locate potential child victims, to promote child trafficking (Merdian *et al.,* 2011). It is thought that child pornography use, or child sexual exploitation via the Internet, can occur on its own or in conjunction with contact sexual offending. It has been argued that the use of child pornography can normalise a sexual interest in children, generating fantasies and guides for real-life contact sexual offending (ibid; Taylor, Quayle & Holland, 2001). Merdian *et al.,*(2001)

suggested that the use of child pornography is not essentially different from contact offending. Rather, the use of child pornography can be seen as a process of normalising the actions conducted towards the child victim, as well as the pornography potentially being the outcome of a sexual interaction with the child victim. It has, however, also been argued that for the majority of child pornography users, their online offending had no behavioural link to contact offending (Hanson & Babchishin, 2009; Seto, Hanson & Babchishin, 2010). This leads to suggestions that there is differences between individuals who solely use child pornography and *do not* contact offend, and those who *do* commit acts of CSA. Leading to questions of whether individuals, who are sexually attracted to children, who do not use the Internet *or* physical means to act upon their sexual interest in children are different again?

The scope of exploring the entirety of ISO literature falls outside the realms of the present research, however, literature that is directly applicable to the present research will be covered within the literature sweep[4].

1.1.4 Defining the target client group

Distinguishing the difference between contact offenders, child pornography users, and potential offenders highlighted many debates within the psychology field. For example, what is the difference between a contact offender and a child pornography user? Both have 'acted' upon their sexual attraction to children, however, only one did so physically (for example sexual contact or

[4] This is covered specifically within pg.22-34 in the literature exploring the field of sexual offending.

sexual intercourse). Research conducted by Merdian *et al.,* (2011; 2014; 2016) highlighted that there were differences between these two groups of sexual offenders. Merdian *et al.*, (2014) found that child pornography users, in comparison to contact offenders, were much less likely to agree with statements which would locate the blame of their actions towards another or an external reasoning. It was also found that child pornography users showed a heightened awareness of consent issues surrounding adult-child interactions, specifically sexual encounters.

Merdian *et al.,* (2014) described a continuum between those who hold a sexual interest towards children and those who have committed a contact offence where the victim was a child. The continuum is suggested to start at a 'fantasy-driven' level, where the individual is thinking sexually about a child and potential CSA. The continuum then moves forward in severity of thought towards acting, or 'contact-driven', where the individual physically engages in CSA. Merdian *et al.,* (2014; 2016) argued that child pornography users should be located at the centre of this continuum, due to their viewing/downloading of child pornography combining both the cognitive ('fantasy-driven') and the behavioural ('contact-driven') elements. It could therefore be suggested that 'potential offenders' (those who are sexually attracted to children but have not used the Internet or physical means to act upon their attraction) would fall at the 'fantasy-driven' end of the continuum, with convicted child sexual abusers falling at the 'contact-driven' end.

As no research has been conducted (to the best of the researcher's knowledge) into the similarities and differences between those who hold a sexual interest in children (and have in no way acted upon their attraction) and those who use child pornography, a similar assumption is made to that made by Meridian *et al.,* (2014); as child pornography users are not to be treated like contact offenders unless supportive research evidence indicates otherwise, 'potential offenders' (those who have never acted upon their sexual attraction to children) are also not to be treated like either contact offenders or child pornography users unless research indicates otherwise. For the purpose of the present research, it is therefore, only those individuals who fall within the fantasy-driven end of the continuum (individuals who have not acted either physically or through the use of the Internet to act upon their sexual attraction to children) who will be used as the target group of clients that the participants will be required to have worked with.

1.2 Field of Counselling Psychology

The field of Counselling Psychology is a relatively young profession, dating back only to 1982 (Strawbridge & Woolfe, 2010). However, since its origination it has continually increased its areas of interest, stepping into realms previously associated with Forensic, Health and Educational Psychology. Alongside this, the role of the Counselling Psychologist is also continuing to widen, expanding not only the variety of clients that a clinician is expected to see, but also increasing the knowledge base a clinician is expected to be able to implement if necessary. The current social demand to stop child sexual abuse

(CSA[5]), could be said to place a mounting social pressure on Counselling Psychology to act; exploring new treatment options, extending beyond those originating in other psychological professions (such as forensic), incorporating new perspectives.

Historically, individual's accessing psychological treatment for thoughts and behaviours linked to CSA have already been criminally charged. Because of this, individuals are likely to be engaging with Forensic Psychologists as part of their treatment, often within prison or rehabilitation settings. However, an increasing number of clients are attempting to access psychological support *prior* to offending, hoping to prevent acting upon their sexual attractions (Beier *et al.,* 2009a; Van Horn *et al.,* 2015). Through linking up with agencies such as 'Lucy Faithful Foundation (LFF)' or 'StopSO', prospective clients are referred to Forensic Psychologists, Counselling Psychologists and Psychotherapists while the client is still in the community. Likewise the number of individuals disclosing such sexual preferences within private therapy is also increasing (NatCen Social Research, 2014), highlighting a need to provide services and support to individuals who remain outside of the forensic system. It could therefore be said that it is the duty of Counselling Psychologists to ensure they are armed with knowledge of how to effectively treat this population, meeting their ever-growing demand for help.

The present research explores the role Psychologists and Psychotherapists play in the treatment of individuals who are sexually attracted

[5] Please refer to Appendix 17, pg.233, for a definition of CSA

to children, but have not acted. The majority of the experiences captured will therefore fall within community services, or private practice, rather than forensic settings where existing literature has traditionally stemmed from. The aim was to explore and identify factors that have shown to be effective in aiding people to abstain from their sexual attraction to children, investigating how Counselling Psychology can incorporate these factors into psychological treatment for individual's wishing to access help.

1.3 Rationale

CSA presents a universal problem and an ever-increasing challenge for authorities implementing health and social policies. The field of sexual offending is a convoluted subject area, and one that is continually debated at the highest levels within healthcare professions, legal departments, Parliament and by members of the public. A study conducted six years ago estimated that in Europe one-in-five children were victims of CSA (Council of Europe, 2010). Statistics released by the Home Office (Crime Statistics in England and Wales (CSEW), 2016) reported a 29% increase in the total number of sexual offences reported to the police in 2015. It is unknown whether this increase in reporting is due to a greater number of offences being committed each year, the impact of Operation Yewtree[6] or better reporting by the police (CSEW, 2016). However, the continuing increase is a cause of concern for authorities wishing to remove CSA from society.

[6] Please refer to Appendix 18, pg.233, for a definition of Operation Yewtree.

The documented 29% increase accounts for all forms of sexual offences including both child and adult victims. However, almost half (44%) of this increase in sexual offending directly related to CSA. This is a startling statistic, demonstrating that for the first time in the UK (since records began in 2002) the number of sexual offences committed within a 12-month period exceeded 100,000 (CSEW, 2016). Moreover, the NSPCC reported that in 2015 alone more than 36,000 records were logged of CSA (Jutte *et al.,* 2015), with a further 2,800 children being identified as at risk of being a victim of CSA (NSPCC, 2015). Furthermore it is suggested that 1-in-20 children in the UK will have experienced CSA (Radford *et al.*, 2011), a figure that is suggested to rise alongside the number of reports of CSA increasing.

It has been estimated that the current epidemic of CSA is costing the UK an average of £3.2 billion each year (Saied-Tessier, 2014). This figure accounts for all health concerns as a direct or indirect consequence of sexual offending, legal costs, the use of services for children (such as social services) and a subsequent loss of productivity in society. When considering the large increase in reports of sexual offending, as well as the amount of money spent each year tackling the consequences of CSA, it could be argued that the current strategies deployed within the UK to tackle CSA are not working. One strategy that could be used to reduce CSA is early interventions (Jutte *et al.,* 2015). By focusing on strategies to stop the offending from occurring in the first place, the total number of CSA cases could reduce, thus reducing the overall economic and societal impact.

The protection of children remains paramount within society, and is therefore fundamental to the present research. However, rather than following the pattern of previous literature, the present research aims to explore the support that is offered to 'potential offenders' (those who identify with paedophilic/hebephilic tendencies but have not acted upon their sexual attraction) prior to offending. The present research is based on the premise that it is time to try something new, tackling CSA from a different angle. It will explore, from a therapist's perspective, what factors aid an individual to abstain from acting upon their sexual attraction to children, prior to offending, rather than focussing on recidivism.

1.4 Reflexivity

Illuminating any potential researcher bias is essential within qualitative methodologies due to the subjective nature attributed to analysis and subsequent findings. As put forward by Mills, Bonner & Francis (2006b), we are all influenced by our personal histories, interactions and cultural contexts. These influences impact how we, as researchers, shape our findings and meanings. Thus, it is important to explore my own potential biases surrounding this research, what led to an interest in this research, as well as addressing my hopes for the research moving forward.

Having grown up in an era where sexual offending has become mainstream within the public eye - through the public following of prosecuting sexual offenders such as within Operation Yewtree – I have always found this an

accessible topic to openly explore. My interest magnified further after finding out a childhood neighbour had been arrested for child related sexual offences. After listening to the community's response to this, I realised there was no talk of help, or what could have been done differently. It was a society whose frantic attempts to shun such individuals overpowered any human offering of help. This appeared to cement my direction of interest, *was there anything we could do to help people before they might offend?*

My intention for this research was to explore what could help/hinder individuals who are sexually attracted to children to avoid acting upon their attraction through using a client-based sample. However, using this population did not comply with University of Roehampton's safeguarding and ethics policies. If disclosure of criminal acts were made then there would be a duty of care to inform the authorities, thus breaching the confidentiality of the sample. Nevertheless, wishing to pursue with the research by any means possible I agreed to University of Roehampton's ethics board suggestion and amended my research to use psychological professionals as the sample instead.

From the beginning I considered that the sharing of similar assumptions between participants and myself would undoubtedly have an impact upon the research findings (Madill, Jordan & Shirley, 2000). Recruiting for Psychologists, Psychotherapists and Counsellors who have worked with individuals who self-identify as being sexually attracted to children could already be argued to remove a large proportion of the general population who consider this group either undeserving of help, or potentially 'untreatable'. It is also undeniable that

this research had the purpose of exploring factors that could contribute to a client abstaining from their sexual attraction, and consequently also helping to address and improve the wellbeing and safety of children. However, having encountered the destruction that CSA can cause to a family, I was mindful that there is a necessity for honesty rather than fallacy. Thus I endeavoured, despite my empathic understanding towards the participants and the research topic (Moustakas, 1990), not to form assumptions that there would be any factors that could help this specific population of potential offenders.

Throughout the research process I ensured to capture my own views, through the recording of reflexive memos (Birks & Mills, 2011), making certain that I was aware of how my perceptions, beliefs and experiences could filter into the data collection and analysis. I also ensured that my line of questioning was grounded within the data collected from participants and previous literature from the field. Reflexivity will be discussed again in the final chapter of this thesis, with a reflection on how my stance could have affected the research process.

1.5 Summary

This chapter has explored the concepts that are to be used throughout this research; defined terms such as paedophilia and hebephilia will be used frequently moving forward. This chapter also outlined my reflexivity, and this awareness will be carried through the following chapters. The next chapter explores the existing literature surrounding the fields of sexual offending,

paedophilia, and introducing ‘Project Prevention Dunkelfeld’ which is undertaking a revolutionary stance towards working with individuals who are sexually attracted to children, but do not wish to act upon their attraction.

Chapter II: Literature Review

2.1 Introduction

This chapter offers a critical review of the literature on sexual offending and paedophilia/hebephilia forming the basis for the research question(s). Through exploring previous literature on this chosen phenomenon, a gap in the field was identified, upon which the final choice of methodology and research methods was based. In addition to this, the literature discussed was used continuously throughout the analysis, through directing lines of enquiry and providing novel means for refining the overall grounded theory (Charmaz, 2006).

Exploring the literature on paedophilia/hebephilia necessitated exploring both sides of the offending spectrum, exploring research conducted on individual's who had an attraction to children but *had not* acted upon their attraction, through to exploring research into convicted child SO (CSO). As the literature on potential offenders has stemmed from the existing research on convicted SO, the therapeutic treatment offered to SO will be considered. Accordingly, the chapter begins with an overview on the treatment options available to SO, moving onto the European outlook on individuals' classified as potential offenders. Finally, the literature explores what could be of benefit or hindrance to individuals who are wishing to abstain from acting on their sexual attraction to children. Through providing a critical review of the literature and

identifying a gap, I argue that more research into the field of paedophilia/hebephilia and potential offenders is required.

2.2 Sexual Offenders (SO)

2.2.1 Introduction

2.2.1.1 Pathways to Offending

Understanding the different pathways to offending has been argued to be pivotal if, as a profession, we able to reduce (re)offending. It is thought that through establishing an understanding on the different pathways that could lead to sexual offending, practitioners could be better able to determine risk management, and thus more effective treatment programmes could be developed. Historically research surrounding the pathways to sexual offending has occurred through the use of a convicted SO sample.

The most common pathways to sexual offending, as presented within the existing research literature, are:

- Sexual deviancy, or holding a sexual interest towards a socially unacceptable target such as children, (Hanson & Harris, 2000; Hason & Morton-Bourgon, 2005).

- Difficulties in achieving and utilising self-awareness (Hanson & Harris, 2000).

- Pro-offending behaviours (Beech, Friendship, Erikson & Hanson, 2002). This particular pathway to sexual offending has also been suggested to include cognitive distortions (Finkelhor 1984; Ward & Brown, 2004).

Different tools and risk assessment measures have been developed over the recent decades in an attempt to determine an individual's risk of recidivism (reconviction for offending behaviours). One such measure is the Structured Assessment of Risk and Need-Treatment Needs Analysis (SARN-TNA). This particular tool is used throughout the British custodial and probation service. The tool is designed to highlight dynamic risk factors (or treatment needs) for specific individuals, leading to a tailored treatment which focuses work on the risk factors most relevant to each client (Tully, Browne & Craig, 2015). The four domains (and thus risk factors) covered by the SARN-TNA are: sexual interests, offence supportive attitudes, relationships and self-management. The recent work by Tully, Browne & Craig (2015) has highlighted that sexual interest was a significant predictive factor of recidivism rates. When exploring the predictability of the SARN-TNA it was found that the measure of an individual's sexual interest was the only domain that held significance in its ability to predict

recidivism (ibid). Similarly, work by Craig *et al.,* (2007) and Hanson & Morton-Bourgon (2005) also found sexual deviancy, or an individuals sexual interest, was both the most established and the greatest predictor of recidivism.

Research conducted by Ward & Beech (2006) highlighted having a sexual interest in children as an important factor in the development of sexual offending. As stated above, this is also significantly related to recidivism (Hanson & Morton-Bourgon, 2005; Tully, Browne & Craig, 2015). Sexual interest has been suggested to include physiological responses as well as sexual fantasies (Bartels & Gannon, 2011; Chivers, 2005). Recently, it has been suggested by Bartels *et al.,* (2016) that individuals who have committed a sexual offence against a child have a stronger associative bias for children and sexual fantasy when compared to controls and those who have committed sexual offences but the victims were not children. Thus, it cannot be ignored that having a sexual interest, or attraction, towards children could increase your likelihood of (re)offending (Bartels *et al.,* 2016; Tully, Browne & Craig, 2015). It is therefore considered that such individuals are likely to require help and support in order to manage their sexual interests should they be able to refrain from acting upon them.

Due to the nature of the present research, and it's focus on those who have not committed a sexual offence, understanding the sexual interest an individual holds and the impact this sexual interest has is of primary importance. While little is known in regards to the differences between convicted SO and those who are attracted to children but have not acted upon their sexual attraction, it is interesting to note that having a sexual interest in children is the

most significant predictor of recidivism within SO samples (Hanson & Morton-Bourgon, 2005; Tully, Browne & Craig, 2015). The present research is therefore mindful that factors that could help or hinder an individual's ability to abstain from acting upon their sexual attraction to children could be based around impacting an individual's sexual interest.

Despite research suggesting sexual interest is the greatest predictor of recidivism, it is also of interest to explore and understand the impact other pathways to sexual offending have on individuals, and how these have been incorporated into treatment. The next section of this chapter will focus specifically on SO. Each of the treatment options discussed in relation to SO are related to the pathways listed above, for example the anti-libidinal treatments are thought to directly impact an individual's sexual interest, and the Pre-Condition Model (Finkelhor, 1984) and the Good Lives Model (Ward & Brown, 2004) address the pro-offending attitudes and behaviours, the relationships an individual holds, as well as an individual's self-awareness. Other potential pathways to offending, such as loneliness, poor self-efficacy are also discussed within this chapter.

2.2.1.2 Treatment for Sexual Offending

Currently there is little agreement amongst Forensic, Counselling and Clinical Psychology research as to the success of treatment offered to SO (Grady, Edwards, Pettus-Davis & Abramson, 2012). Treatment "success" in this instance refers to the reduction of recidivism rates, specifically the reduction of CSA in

this instance. While on one hand there is evidence supporting reductions in recidivism rates when therapeutic treatments are incorporated into sex offender treatment programmes (Lasher & McGrath, 2012; Marques, Wiederanders, Day, Nelson & Ommeren, 2005; McGrath, Lasher, Cumming, Langton & Hoke, 2013); on the other hand, this reduction is insignificant when compared to recidivism rates of SO who did not undergo therapeutic treatment.

While not all SO receive therapeutic treatment, due to the voluntary nature of participation, this will be the primary focus on existing SO literature within the present research. This is due not only to its relevance to Counselling Psychology, but also as factors found to be useful in reducing the likelihood of reoffending *could* be relevant for those who have not acted on their attraction. The literature sweep will explore leading treatment models currently used within the field of sexual offending, including the role of anti-libidinal treatments, Finkelhor's (1984) Pre-Condition Model and the Good Lives Model (Ward & Brown, 2004).

2.2.2 Anti-libidinal Treatment

The use of 'chemical castration' within the field of sexual offending has ignited many ethical, moral and legal debates. Currently seven prisons within the UK use anti-libidinal drugs in the treatment of convicted CSO (Casciani, 2016), the majority of whom display paedophilic tendencies. Whilst many countries worldwide approve using pharmacological treatments with SO, the use of such drugs for potential offenders raises numerous concerns in regards to

establishing efficacy (Marshall & Marshall, 2007; Melella, Travin & Cullen, 1989; Thibaut *et al.,* 2010). One concern is the process of empirically establishing effectiveness; commonly this is done through the use of a randomised controlled trials, however, many psychiatrists and ethical committees question the ethics and legality of providing a potential offender with a placebo rather than an anti-libidinal drug (Marshall & Marshall, 2007; Melella, Travin & Cullen, 1989).

Empirical evidence highlighting the effectiveness of androgen deprivation therapy (one form of anti-libidinal treatment) is currently lacking and/or displays conflicting results (Amelung *et al.,* 2012; Rice & Harris, 2011). Research exploring CSO adherence to different treatment options highlighted that individuals were much more likely to adhere to psychological treatments than anti-libidinal treatment (Hall, 1995), despite many CSO reporting their belief that taking part in anti-libidinal treatment would be advantageous for them with regards to legal proceedings (Amelung *et al.,* 2012). Their heightened motivation to take part in anti-libidinal treatment therefore makes the attrition rates all the more surprising. Whilst attrition could be explained due to a multitude of reasons (realising it was not advantageous, experiencing side effects from the medication, preferring to have a sexual libido etc), the fact that attrition levels are significantly higher when compared to psychological treatments suggests that focusing time, effort and funding towards psychological treatments could result in not only reaching a larger number of CSO, or potential offenders, but also prove to be more effective due to treatment adherence.

Despite the criticisms of this form of treatment for potential offenders, research is taking place in Sweden into trialling anti-libidinal medication for individuals with sexual preferences towards children (Casciani, 2016). As this research is in its initial recruitment phases, the effectiveness of such medication cannot yet be reported on or established. Despite this, there is heavy media coverage (such as: Casciani, 2016; Rabesandratana, 2016; Reilly, 2016) and interest in the research demonstrating a shift in society's ability to acknowledge the existence of such individuals. It is also encouraging that areas previously associated with treating SO are now being re-explored within research, with a shift in the focus towards prevention.

2.2.3 Finkelhor: The Pre-Condition Model

The ethical considerations of "chemical castration" led to research switching its focus to explore the benefits of therapeutic treatments. In 1984, Finkelhor put forward a model for offending which is still referred to over thirty years later: The Pre-Condition Model. According to The Pre-Condition model an individual is only able to commit acts of CSA after certain pre-conditions have been met. Four conditions are suggested to represent the integration of biological, psychological, developmental and opportunistic factors behind sexual offending (Finkelhor, 1984).

Finkelhor (1984) outlined the first condition to be the individual's motivation and desire to commit a sexual offence. The second condition is for the individual to overcome their psychological inhibitors which would prevent them

from acting on their sexual desire. Psychological inhibitors can include the individual's moral or cultural beliefs, the fear of getting caught or empathy for the child. This condition is followed by: overcoming external inhibitors. These are variables external to the individual that are often difficult to control such as access to a child, vigilance of parents, and the impact of grooming a child. The final pre-condition that requires overcoming if CSA is to occur is the resistance from the victim. Individuals who desire to complete a sexual act with a child, if not consensual, may resort to threats, physical dominance, coercion or psychological shaming in order to overcome any resistance from the child (Finkelhor & Araji, 1986).

A vast amount of research has been carried out exploring supporting evidence for Finkelhor's model (Allam, 2000: such as; Sullivan, 2009; Whittle, Hamilton-Giachritsis, Beech & Collings, 2013). The first pre-condition, motivation, has been found to be in connection not only with arousal by children (Ward, Hudson & France, 1993), but also with a difficulty in forming adult relationships (Marshall *et al.,* 1999) the latter of which could impact on both pre-condition two and three. Research conducted with SO has highlighted that there is a common pattern of using cognitive distortions in order to justify or rationalise behaviour. These cognitive distortions will aid in the overcoming of any psychological (internal) inhibitors (Ward, Hudson, Johnson & Marshall, 1997). The emphasis on cognitive distortions from this model has resulted in the measures and techniques used within the majority of sex offender treatment programmes (SOTP) used worldwide.

2.2.4 Sex Offender Treatment Programme: UK criminal justice system

Over the past three decades there has been a substantial shift in the management and treatment of SO, moving from a punitive to a rehabilitation approach (Friendship, Mann & Beech, 2003; McGuire, 1995). Most notably, there has been an increase in the use of Cognitive Behavioural Therapy (CBT) within the treatment of SO (Ward & Gannon, 2005). It is often thought that individuals who commit anti-social behaviours, such as CSA, do so due to their tendency to minimise and distort the reality of their behaviour (Conte, 1991; Swaffer, Hollin, Beech, Beckett & Fisher, 1998), commonly in the form of cognitive distortions (Lanyon, 1991). Thus the use of CBT has presented as a suitable and effective candidate in the treatment and reduction of sexual offending (Ward & Gannon, 2005). The preference for CBT within treatments for SO is so great that the Association for the Treatment of Sexual Abusers (ATSA, 2005), who oversee the treatment for SO, have suggested within their "Practice Standards and Guide" that the use of CBT should be employed within all contemporary treatments offered to SO.

In 1992 the national SOTP was established in America incorporating CBT into treatment (Beech, Fisher & Beckett, 1999; Mann & Thornton, 1998). The popularity of these approaches resulted in the quick implementation of copycat programmes across prisons worldwide. However, the classification of programmes as 'cognitive-behavioural' has been suggested to be problematic, due to the lack of uniformity in the treatment provided to SO (Marshall &

Marshall, 2010; McGrath, Cumming & Buchard, 2003; McGrath, Cumming, Buchard, Zeoli & Ellerby, 2010).

In one SOTP, SO were asked to recount their offence based upon the (1984) Finkelhor model (Friendship, Mann & Beech, 2003); this was followed by exploring, challenging and confronting the offender's cognitive distortions (ibid), aiming for the offender to take responsibility for their actions (Murphy, 1990). Subsequent therapeutic sessions focussed on victim empathy, childhood experiences, decisional matrix exploring the cost and gains of their offending behaviour, and the cycle and patterns of their offending (Wolf, 1989). Completion of this SOTP included the incorporation of relapse prevention, exploring the offender's high-risk situations and triggers to lapsing (Friendship, Mann & Beech, 2003). In contrast, another SOTP is more detailed in both length and depth. The overall programme was slowed, allowing for detailed exploration with offenders about their cognitive distortions rather than the confrontational technique described previously. Role-play exercises were included to aid in the exploration and establishing of victim empathy. Finally, relapse prevention was expanded including a focus on coping strategies for when offenders found themselves in a high-risk situation (ibid). The differences within SOTP could be argued to demonstrate a lack of clarity towards the most effective treatment for SO.

2.2.5 The Good Lives Model (GLM)

Similar to other models used within the treatment of SO, the GLM (Ward & Brown, 2004) incorporates an exploration of risk factors for reoffending. Unlike other approaches, the GLM perceives risk factors to be distortions within an individual's internal and external ability to satisfy their needs (including sexual); GLM risk factors are classified as internal and/or external obstacles that impede an individual's ability to obtain primary goods (ibid). The GLM focuses on individuals achieving a healthy functioning, greater knowledge, mastery of different experiences, excellence in autonomy and agency, finding inner peace, building friendships and relationships, building a sense of community, happiness and creativity (ibid). These are all classed as "primary goods" and are based upon biological, psychological and social findings from research literature (Aspinwall & Staudinger, 2003; Linley & Joseph, 2004; Murphy, 2001; Ward & Gannon, 2005). Risk is determined as an individual's use of inappropriate means to achieve their primary goods, examples of risk factors are: an individual not addressing all of their primary goods, incoherence between how their goods are sought, and finally a lack of skills in order to achieve the primary goods (Ward & Brown, 2004).

The GLM aims to promote a better life for offenders, reducing the likelihood of needing to, or wanting to, offend. It was built on the premise that focusing on risk factors and the development of relapse prevention techniques were necessary but not sufficient in the treatment of SO (Ward & Gannon, 2005; Ward, Hudson & Keenan, 1998; Ward & Stewart, 2003). It was suggested that

including an additional focus on developing methods with offenders on how to meet their human needs in a more adaptive way would reduce the risk of harm to themselves or others (Ward & Stewart, 2003). This would include focusing on conditions such as aiding the offender with their skills, opportunities and social support. The GLM aims to promote the welfare of the offender, focusing on instilling and building an individual's strengths, rather than merely focussing on any deficits they may have (Aspinwall & Staudinger, 2003). The aim of GLM is to teach offenders how to effectively gain primary goods in an adaptive way when out in the community, reducing their need to offend in order to meet their needs (Ward & Brown, 2004).

The implementation of the GLM has shown effectiveness in reducing recidivism rates within SO (Ward & Brown, 2004; Ward & Gannon, 2005; Lindsay, Ward, Morgan & Wilson, 2007). One reason behind the effectiveness is thought to be the offender's willingness to engage in the treatment, possibly through focusing the treatment on the needs of the offender (Whitehead, Ward & Collie, 2007). However, the significance of this has been disputed and critiqued due to apparent weaknesses in theory and its subsequent practical implications (Andrews, Bonta & Wormith, 2011; McMurran & Ward, 2004; Ward, Polaschek & Beech, 2006).

While the GLM presents as an all-inclusive treatment for SO, offering a strengths based approach rather than reflecting their cognitive distortions, it falls into the same premise as the SOTP before it: punish first, treat second (LaFond, 2005). Therefore, while offering a perceived improvement in the

treatment of SO, potential offenders continue to be missed in the treatment options available. Despite calls in 1998 to switch the focus from relapse management to prevention (Freeman-Longo & Blanchard, 1998), the development of SOTP continues, by their very nature, to focus on those convicted of a sexual offence. Due to this, the literature sweep will move to explore the changing tide, where potential offenders are taking centre stage.

2.3 A European outlook on 'potential' offenders

2.3.1 Introduction

Prevention programmes, which have redirected the focus towards potential offenders, are currently lacking in development in comparison to the existing programmes for SO (Van Horn *et al.,* 2015). However, the limited research that does exist shows great promise in offering preventative treatment options for paedophiles/hebephiles. Europe, and in particular Germany, is revolutionising the way this client group is considered, both clinically and within the research community. As the present research is based within the UK, where the development of psychological treatments is heavily influenced by Europe, a European outlook on the existing prevention programmes will be explored. The most well-known and well researched of European prevention programmes will be discussed below, however, it is acknowledged that there are likely to be many more different programmes such as 'StopSO'.

2.3.2 Stop It Now!

'Stop It Now!' focuses on the prevention of CSA (Van Horn *et al.,* 2015). Unlike the SOTP developed for the criminal justice system, with a focus on incarceration and rehabilitation, Stop It Now! aims to explore the strategies that could prevent CSA from occurring in the first place. The original programme developed by Stop It Now! sought to encourage communities to take action to protect children *before* they were harmed. One method is the use of a free anonymous helpline for potential offenders who are worried about the sexual fantasies they may hold towards children (ibid). Since it's origination in 1992, Stop It Now! has expanded to the UK in 2002, and the Netherlands in 2012. As the present research will be based in the UK, only the UK branches of Stop It Now! were explored further.

2.3.3 Lucy Faithful Foundation in association with Stop It Now!

Lucy Faithful Foundation (LFF) is a charitable organisation focusing specifically on reducing CSA. LFF and Stop It Now! are underpinned by the belief that adults are responsible for the prevention of CSA (Philpot, 2002; Van Horn *et al.,* 2015). The Stop It Now! helpline engages not only with potential offenders, but also aims to provide guidance for carers, parents and professionals with the hope of increasing awareness of CSA within communities (Philpot, 2002). Whilst LFF and Stop It Now! UK offers support to many subgroups, including survivors of CSA, for the purpose of this research only the work they conduct with SO and potential offenders were considered further.

LFF practitioners offer short-term support to target callers with complex issues surrounding their sexual attraction to children. This support can be conducted either over the phone or in person. Unlike their European counterparts, the service offered by LFF beyond the initial helpline interaction is not free of charge due to a lack of funding by public health boards. Research into the effectiveness of the helplines run by LFF & Stop It Now!, in regards to the prevention of CSA, have found tentative but promising results. Van Horn *et al.,* (2015) explored the self-reports of individuals who used the helplines and found the majority reported their belief that the helpline had helped them to not (re)offend. However, there were also numerous barriers to accessing help such as denial, minimisation, shame, fearing the consequences of disclosing their thoughts and feelings, as well as a considerable lack of resources in the UK (ibid). As funding is currently not available for advertising nationally about the services offered by LFF (and Stop It Now! UK) it could be argued that a large proportion of potential offenders are still unaware of the support that is available to them. Secondly, as anonymity for individuals' reporting sexual feelings towards children cannot be guaranteed within the UK due to statutory legislation[7], it is likely that this is a large barrier for individual's wishing to access help.

[7] Please refer to Appendix 19, pg.234, for a definition on statutory regulations, and, Appendix 3, pg.210, for the Children Act 2004.

2.3.4 Project Prevention Dunkelfeld: Revolutionising paedophilia & hebephilia

Following years of research into SO, and the associated treatments, mixed results were found in regards to effectiveness in reducing recidivism rates. It has been suggested that a change of direction is necessary if there is to be a reduction in the number of CSA cases (Freeman-Longo & Blanchard, 1998). Beier *et al.,* (2009b) argued that one plausible approach is targeting community based treatments for potential offenders, rather than potential victims. One-step towards this is the development of Project Prevention Dunkelfeld (PPD). PPD is a project set up in Germany revolutionising the way treatment is offered to individuals identifying with paedophilic/hebephilic tendencies. PPD aims to prevent CSA using a novel approach: targeting males who self-identify as fearing that they will commit acts of CSA and wish to receive help to prevent this (Beier *et al.*, 2009b). PPD offers psychological treatments, in the form of CBT, to clients.

Research from PPD demonstrated that potential offenders could be accessed through extensive media campaigns (Van Horn *et al.,* 2015), attracting paedophiles/hebephiles who had never been involved with the criminal justice system. This previously untapped population were now given the option of attending for treatment without the fear of being reported to the police. Within the first 3 years of advertising PPD received over 800 responses from members of the public. All of whom expressed concerns about their sexual attraction to children (Beier *et al.*, 2009a). This figure has grown to almost 6,500 phone calls from 2005 to 2016. The apparent success of PPD in attracting paedophiles/hebephiles to seek treatment for their sexual preferences has been

ground-breaking. Yet, when looking at the statistics behind the individual's wishing to seek treatment, it was noted that clients were calling the German service from many other European countries including Austria and the UK (Beier *et al.,* 2009a).

2.3.5 Comparing Project Prevention Dunkelfeld to the UK: is the UK turning a blind eye?

As stated above, during its first three years the German service, PPD, received over 800 responses from individual's wishing to access help for their sexual attraction to children. This figure was deemed a resounding success; potential offenders had heard their message and were wishing to receive treatment for their sexual preferences (Beier *et al.,* 2009a; 2009b). However, if these statistics are compared to statistics from the UK, the number of individual's contacting PPD is significantly lower. Beier *et al.,* (2009a) highlighted that during a comparable time period of three years, the Stop It Now! UK & Ireland branches had received over twice as many phone calls from potential offenders than received by PPD. This is a significantly larger amount of phone calls even before the size of populations between Germany and the UK is taken into consideration[8]. While it is not suggested that the UK has more paedophiles/hebephiles, it is interesting to note that there is a greater perceived need for help from individuals in the UK than in other European countries. The increase in phone calls received in the UK has led to questions of why the UK does not have a similar project to Germany.

[8] The current populations are estimated to be 80 million in Germany and 64 million in the UK

It appears that while the UK is financially investing in the field of CSA, we are falling behind other leading countries in the services offered to potential offenders. This is demonstrated by a surprising lack of research originating from the UK into the field of "potential offending", the lack of funding provided to services such as LFF, and statutory regulations impinging upon a client's right to confidentiality. Whilst it has been shown through data collected from LFF, Stop It Now!, StopSo and PPD that there is an outcry for help from potential offenders, the treatment offered to this client group can only be effective if, as clinicians, we understand what help/hinders an individual's ability to abstain from acting upon their sexual attraction to children.

2.4 Factors for and against: understanding an individual's ability to abstain from their sexual attraction to children

2.4.1 Introduction

Research literature into SO is vast, with the majority of studies focussing on individuals who have committed CSA. However, it has been suggested that in order for preventative strategies to be developed, an understanding is required about factors impacting potential offenders (De Vries Robbe, Mann, Maruna & Thornton, 2015). Following the model put forward by Finkelhor (1984), Neutze *et al.,* (2010) suggested that it was the influence of psychological factors that impact upon an individual's ability to abstain from their sexual attraction. Factors that influence an individual's likelihood to act upon their sexual

attraction are classified as *dynamic* factors (Neutze *et al.,* 2010); and are assumed to be linked to an individual's likelihood of (re)offending and/or their potential responsiveness for treatment. Addressing dynamic factors is suggested to be important in the formation of treatment targets within the field of sex offending (Andrews & Bonta, 2006; Marshall, Marshall & Serran, 2006) if effective preventative treatments are to be developed (De Vries Robbe *et al.,* 2015; Van Horn *et al.,* 2015). Whilst the number of factors that could influence this process could be classed as infinite, and dependent upon detection status as well as their sexual preferences (Neutze *et al.,* 2010), a number of the most prominent factors within the literature will be explored below.

2.4.2 Emotional & Intimacy Deficits

Much research has been conducted into the differences between a SO sample (including ISO) and controls (Marsa *et al.*, 2004; Neutze *et al.,* 2010). One aspect of emotionality that has shown to be effective, and a moderating factor, in relapse management of CSO is self-efficacy (Hall, 1989; Tozdan & Briken, 2015), with individual's who express an improved self-efficacy being less likely to return to offending. Moreover, Shingler & Mann (2006) found that paedophiles/hebephiles, who perceived themselves as lacking self-efficacy, were likely to display non-compliance with their treatment, further highlighting the importance building a strong self-efficacy can have for this population. Self-efficacy could boost an individual's belief in their ability to not act upon their sexual attraction, thus making it a dynamic factor influencing both those who have offended, and potential offenders.

In addition, when comparing levels of loneliness between non-offenders and SO, it was determined that SO were more likely to experience heightened levels of loneliness and intimacy deficits (Hanson *et al.,* 2007; Marsa *et al.*, 2004; Whitaker *et al.,* 2008). While no research has demonstrated whether it is a cause or effect of their sexual attraction, the presence of loneliness and intimacy deficits will undoubtedly be of interest to psychological professionals working with potential offenders.

2.4.3 Stigma

Paedophiles are thought to be the most stigmatised and rejected population within mental health services (Feldman & Crandall, 2007), due to their attraction being focused on an 'innocent' population (children). When in forensic settings it is often CSO who are deemed the most vulnerable (Lowndes, 2015). In a survey conducted with English speakers it was found that 27% thought paedophiles would be better off dead (Jahnke, Imhoff & Hoyer, 2015). This statistic highlights the stigma faced by individuals aligning with paedophilic tendencies, resulting in many attempting to deny and suppress their feelings (Neutze, Grundmann, Scherner & Beier, 2012).

In addition, a survey conducted in Germany with psychological professionals highlighted that 95% of respondents *were not* willing to work with individuals who self-identify as having a sexual preference towards children (Stiels-Glenn, 2010). This figure is thought to be as a result of negative attitudes

towards paedophiles (Jahnke, Philipp & Hoyer, 2015). Furthermore a study conducted in America pinpointed predictions of individuals feeling they were stigmatised as one of the main reasons why paedophiles may not access psychological support (Kramer, 2011). It has been argued that if preventative measures to reduce CSA are to be effective, a prerequisite to success is reducing the stigma surrounding this group (Jahnke, Philipp & Hoyer, 2015).

One explanation behind the stigma towards potential offenders is thought to be due to a lack of understanding of whom a paedophile/hebephile is. Research has shown that the general public are often misinformed on the differences between a paedophile/hebephile and a CSO (McCartan, 2004; 2010); often it is assumed that *all* paedophiles/hebephiles will engage in CSA (Feelgood & Hoyer, 2008; Jahnke, Philipp & Hoyer, 2015). PPD[9] explored the impact of stigma upon paedophiles, and aimed to alter both the public and professional perception. Their manifesto is that paedophiles are not to blame for their sexual attraction, they are however in control of their behaviour (Beier *et al.,* 2009b). This subtle difference aims to inform paedophiles and the wider population that this is a life-long process of establishing and maintaining self-control. It has subsequently been argued that anti-stigma campaigns should be released for both psychological professionals, and wider communities, to improve empathy and sensitivity within practitioners who may work with potential offenders (Jahnke, Philipp & Hoyer, 2015). It is hoped that this could promote a stronger therapeutic relationship and success of therapeutic interventions (Martin, Garske & Davis, 2000).

[9] Please refer to pages 29-31 within Chapter II.

Finally, it could be argued that psychological interventions are always going to lack success, if, as a profession we cannot address this stigma. Not only through reducing the likelihood that an individual would feel able to disclose their sexual attraction without fear of retribution. Therefore it could be suggested that social and professional stigma is a prominent factor hindering an individual's ability to access therapeutic support for their attraction to children.

2.4.4 Legislation

The apparent success of PPD has been attributed to numerous factors. One of which is legislation in Germany differing substantially to the UK (Beier *et al.,* 2009b). Laws on mandatory reporting of planned crimes excludes CSA in Germany (unless there is a risk of homicide), therefore preventing the therapist from breaching confidentiality should such ideation or behaviours be disclosed within the therapeutic relationship (ibid). Any therapist who breaches therapeutic confidentiality under these circumstances can face the loss of their practising licence. This 'favourable' legislation has been suggested to increase the likelihood individuals, in Germany, will be willing and/or able to access support for their sexual attraction to children (Beier, 2009a; 2009b).

While PPD found that favourable legislation in Germany was having a positive impact on the number of people attending for support, PPD have also argued that legislation regarding therapeutic confidentiality and its limitations could be causing large obstacles for potential offenders from accessing help in

other countries (Beier *et al.,* 2009b; Schaefer *et al.,* 2010). Beier *et al.,* (2009b) further argued that the vast majority of paedophiles would like to access help for their sexual preferences and would be much more likely to engage in therapy if they could trust boundaries of confidentiality. This suggestion appears to be shared by the community of individuals identifying as paedophiles/hebephiles, with a quick look on ''PsychForums confirming that many do not wish to seek therapeutic support due to mandatory reporting laws (Clark-Flory, 2016). One user, on a post about seeking therapeutic help for sexual attraction towards children posted, "*I would definitely not tell a therapist. They could help you, but I'm not sure it is worth the risk"* (ibid). It is concerning that mandatory reporting laws could be pushing more people to hide and distance themselves from psychological support, rather than reducing CSA.

For some, the perceived risk of legal and social consequences outweighs any perceived benefits of attempting to access help (Neutze *et al.*, 2012). It could be argued that the increasing number of phone calls that PPD is receiving is due to the increasing trust that they can engage in treatment without fear of reporting, with individuals choosing to call the German service rather than their own (such as LFF) due to the trust they can place in the service to maintain their anonymity. The work by PPD has opened up the debate on mandatory reporting laws in therapeutic environments. Arguments about whether such laws actually cause more harm than protect children rumbles on (Fedoroff *et al.,* 2001; Schaefer *et al.*, 2010). However, there is no denying that the fear of confidentiality being breached will prevent some potential offenders from

accessing therapeutic support and/or deny their sexual preferences (Neutze *et al.*, 2012).

2.4.5 Fearing facing the music: Legal consequences

As stated above, the threat of exposure through mandatory/statutory reporting laws could negatively impact the number of individuals who feel able to seek therapeutic support for their attraction to children (such as Neutze *et al.*, 2012). Research conducted by Mitchell & Galupo (2016) explored the impact that perceived legal consequences would have on individuals considering acting upon their sexual interest towards children. Using a sample of convicted SO and potential offenders the impact of this factor was explored. It was found that in both populations the legal consequences of their actions appeared to be less of a concern (ibid) than a breach of confidentiality. Participant's only discussed this factor after prompting by the researchers, demonstrating that the potential consequence of going to jail was not at the forefront of their minds when considering what would stop them from acting upon their sexual interest in children. While a slight contrast to the findings by Neutze *et al.,* (2012) the findings by Mitchell & Galupo add further weight to the argument that current methods of tackling CSA (through custodial punishments, and treatments being offered *after* conviction) are not working.

The impact of custodial sentences was further explored by Hollin (2002). Hollin suggested that the fear of punishment and legal consequences for sexual offending *did* have an impact, however, rather than being a deterrent, the threat

of a custodial sentence *reduced* the likelihood an individual would access help. In a sample of offenders, it was found that the association of punishment to their actions resulted in a sharp decrease in an individual's motivation to change their behaviour (ibid; Beier *et al.,* 2009a). This supports the suggestion made by Neutze *et al.,* (2012) and demonstrates that advertising lengthy jail sentences within the media, through the coverage of Operation Yewtree and "*Paedophile Hunters"*[10]*,* did not deter an individual from acting upon their attraction. This adds further weight to the argument that there needs to be a shift in UK policies (such as changing reporting laws to be in line with Germany), if as a country we are to reduce the number of CSA cases.

2.4.6 Psychological therapy

The impact of psychological therapy is a growing area of interest within research on SO. It has been suggested that the high co-morbidity rates found within individual's identifying with paedophilic tendencies is increasing the likelihood that they will need to seek out psychological support (Beier *et al.,* 2009a; Stop It Now!, 2007; Tabachnick & Dawson, 2000). This contrasts views that suggested this client group were highly unlikely and unwilling to seek help (Schaefer *et al.,* 2010).

Mitchell & Galupo (2016) found that participants, including SO and potential offenders, did not perceive the offer of mental health treatment as having an influence on their behaviour. Many believed that confiding in a

[10] A television programme on Channel 4 documenting individuals "hunting" paedophiles.

psychological professional, or attending therapy, could worsen their problem. Participants described negative experiences with psychological professionals, with some being "abandoned" by their therapist after disclosing their sexual attraction to children (ibid). This further highlights the issues around stigma discussed in 2.4.3.

Despite the discouraging findings from Mitchell & Galupo (2016), prior research has indicated that psychological input *could* benefit this population (Finkelhor, 2009; Osterheider *et al.,* 2011). It has been suggested that the presence of psychological services, for potential offenders, could have preventative value (Amelung *et al.*, 2012; Beier *et al.,* 2009b; Beier *et al.,* 2015; Grossman *et al.,* 2014; Kim *et al.,* 2015), aiding clients in abstaining from CSA. Jahnke, Philipp & Hoyer (2015) argued that focusing on identifying desire within treatment for potential offenders could prove to be beneficial, significantly reducing the occurrence of CSA (Beiers *et al.,* 2009a; 2009b; Finkelhor, 2009; Jahnke, Philipp & Hoyer, 2015; Osterheider *et al.,* 2011). The demand for psychological support appears to be growing, with research conducted by Fedoroff *et al.,* (2001) showing that potential offenders were seeking treatment even in areas where there were mandatory reporting laws.

However, research has highlighted that currently there is a significant lack of psychological services available to potential offenders in the community (Beier *et al.,* 2009b). The lack of services could be due to a multitude of reasons: lack of funding, stigma, legislation, and a lack of knowledge by professionals on how to help. While each of these factors would need to be addressed

individually, it is necessary to explore clients' reluctance to attend therapeutic services if psychological treatments are to play an effective role in aiding individuals to manage their sexual attraction to children.

2.4.7 Therapist Characteristics

Therapist characteristics have frequently been explored to determine the impact they have on client outcomes (for example: Baldwin & Imel, 2013; Huppert, Bufka, Barlow, Gorman & Shear, 2001; Saxon & Barkham, 2012; Wilson, Wilfley, Agras & Bryson, 2011). Research has highlighted that talking therapies can be effective when delivered by either qualified psychological professionals (Gibbons *et al.*, 2010) or trainee practitioners (Forand, Evans, Haglin & Fishman, 2011). This suggests it is not therapist competency which determines client outcome, but a combination of therapist factors. Furthermore, therapists have been argued to attribute to 5-8% of the variance in client outcomes (Baldwin & Imel, 2013 & Saxon & Barkham, 2012), highlighting the importance of understanding which characteristics of a therapist positively affect client outcomes.

Andrews and Bonta (2006) suggested that rather than the type of therapy offered, it was the therapist providing the treatment that would determine effectiveness for SO. Characteristics such as empathy, interest, respect, and a non-blaming/judgemental communication style were highly important in improving effectiveness of therapeutic treatment (ibid). Andrews & Dowden (2007) also suggest that pro-social modelling, effective disapproval,

effective use of authority and helping build skills around self-management were all important characteristics when working with SO. Furthermore research found that therapists embodying these characteristics when working with SO significantly improved treatment outcomes when compared to therapists who did not have these qualities (Dowden & Andrews, 2003).

When compared to the lack of significance found within the effect of SOTP on recidivism rates, it could be said that focussing on quality and characteristics of therapists is much more likely to reduce CSA. Lopez-Viets, Walker & Miller (2002) found evidence to suggest that therapists need to be able to evoke a sense of hope amongst their SO clients. Moreover, Drapeau (2005) suggested that therapist characteristics such as being caring, honest, respectful, and non-judgemental were all deemed crucial by SO if they were to experience any benefits from attending psychological treatment.

Researchers have also explored the impact of therapist features in Psychological Wellbeing Practitioners (PWP) who work in Improving Access to Psychological Therapies (IAPT). As IAPT uses a step-care model in the delivering of therapeutic treatments it was suggested that therapist features should play little-to-no role in determining outcome for clients within step 1 (where protocols are assumed to be delivered consistently by all practitioners, and therapeutic drift away from the protocols is actively discouraged) (Green, Barkham, Kellet & Saxton, 2014). The research conducted by Green *et al.,* (2014) highlighted differences in outcome rates among the PWP; PWP classed as "effective" were found to be resilient in the face of challenges, and have greater

confidence in their ability to effectively deliver protocols to clients. Green *et al.,* (2014) found this variance accounted for 9% of variance within outcomes. The findings highlight that regardless of the intervention, whether formed of manualised protocols or tailored to the specific client, the characteristics of the therapist will significantly impact upon outcome rates for clients.

When considering the research towards the impact of stigma and the effect of psychological therapies, the impact of the therapist presents as being of paramount importance to potential offenders. It can be argued that therapists have to be willing and open-minded prior to considering working with SO (Mann, 2000; 2001) and potential offenders. Lacking a respectful and non-judgemental standpoint could prove to be damaging for clients, removing any potential benefits from the therapeutic intervention.

As stated at the beginning of this section, the list of factors discussed is by no means exhaustive. However, current trends within existing research leave many questions yet to be answered. What impact does perceived stigma have on individuals attempting to access treatment for their sexual attraction in the UK? What impact does UK statutory legislation have on client's who are sexually attracted to children? And what, if any, benefits do client's report from attending therapeutic support for their sexual attraction to children?

2.5 Overview and critique of the literature

2.5.1 Reviewing the literature and identifying the gap in the field

As witnessed in the literature presented above, there is a startling gap in regards to working with potential offenders/paedophiles/hebephiles. Aside from the research being produced at PPD, and a small minority of other researchers, this population is often overlooked. The research that has been produced is also, in the majority of cases, conducted outside of the UK. This leads to the question of whether the findings is either representative or generalisable to the conditions faced by individuals within the UK, demonstrating the need for further research to be conducted inside the UK. Moreover, research on this topic is limited and there is a need for further research able to produce rich data and deepen the understanding of what helps/hinders individuals who wish to not act upon their sexual attraction to children.

It could be theorised that in the UK it is the combination of different factors which help/hinder an individual in not acting upon their sexual attraction to children. As research literature is now focusing on establishing new and effective techniques to aid the prevention of CSA (Jahnke, Philipp & Hoyer, 2015; Zeuthen & Hagelskjaer, 2013), the present research will continue this trend focussing on what impacts potential offenders in their ability to abstain from their attraction.

2.6 Summary

This chapter has explored the existing literature into the field of sex offending, potential offenders and factors thought to impact SO. It has explored how, to date, there has been little focus on either the current therapeutic climate for clients in the UK who are experiencing a sexual attraction to children, or on what would aid abstinence from acting upon their attraction. The final part of this chapter will discuss the formation of both the research question and the subsequent aims and objectives.

2.6.1 Forming the research question

After exploring the existing literature in the areas of sex offending, and specifically the European approach to working with potential offenders, the initial research question emerged. It was determined that a greater knowledge was required about how psychological professionals, within the UK, work with this population. It was also determined that there was a substantial gap in the research literature exploring what aided/hindered an individual's ability to abstain from acting upon their sexual attraction to children, should they not wish to act. This led to the formation of the follow research question: "what factors, if any, are perceived to impact upon an individual's ability to abstain from acting upon their sexual attraction to children?"

2.6.2 Research aims and objectives

The aim of the present research was to explore the perceptions of Psychologists, Psychotherapists and Counsellors who work with individuals who self-identify as being sexually attracted to children under the age of 16. The research aimed to explore what factors, if any, were perceived to facilitate abstinence and the client's decision to not act upon their attraction.

In order to achieve this aim, the following objectives for the research were formed:

- Recruiting individuals who have worked with at least one client, in a therapeutic context, who self-identified as being sexually attracted to children.
- To explore what participants believe they had learnt from working with this client group, in relation to the strategies, behaviours or other factors that could contribute towards their client's being able to abstain from acting on their sexual attraction to children.
- To explore the participants perceptions of how talking-therapy might impact upon an individual's decision to abstain from acting upon their sexual attraction to children.

Moving forward, the next chapter will build upon the research question, discussing the methodological approach chosen in order to meet the aims and objectives. This will be followed by a detailed discussion of the choice of Constructivist Grounded Theory.

Chapter III: Methodology

As this research is being conducted in partial fulfilment of a Counselling Psychology doctorate the design aimed to not only expand upon existing knowledge in the field, but also produce a framework of understanding for practitioners aiding in their work with clients who identify as sexually attracted to children. In line with Crotty (1998), four elements have been focused on during the designing of the present research: epistemology, theoretical perspective, methodology and methods. Over the course of the next two chapters these elements will be considered, providing the rationale for using 'constructivist Grounded Theory' (Charmaz, 2006) for the exploration of the factors that may help/hinder an individual's ability to abstain from acting upon their attraction to children.

3.1 Research Paradigm

The present research set out to determine if a theoretical framework could be developed to improve the understanding of what could help an individual, who is sexually attracted to children[11], abstain from acting upon their attraction. While both quantitative and qualitative methodologies were considered in order to answer this research question, my own views as researcher naturally impacted this decision. Howell (2013) suggested that all researchers have pre-conceptions about reality, and these pre-conceptions are thought to impact the choice of methodological approach used within data

[11] Please refer to p.8 in Chapter I for the discussion in regards to the use of the term "child/children"

collection and analysis. All quantitative and qualitative approaches offer a unique way of answering research questions, as all methodological options had something to offer the research I was required to locate my ontological and epistemological positions alongside exploring the philosophies of Counselling Psychology.

3.1.1 *Qualitative and Quantitative Research Paradigms*

Determining whether to choose a qualitative or quantitative approach was the first step in the design process. Historically, psychological research has been dominated by quantitative methods (Hanson, 2004), with a perceived need to quantify an experience at the potential cost of losing subjective experiences and meanings in the process (Bruner, 1991). Quantitative methodologies commonly adopt an objectivist and/or positivist stance within ontological and epistemological bases when exploring a given phenomenon (Guba & Lincoln, 1994). Therefore, many psychological theories have been founded upon objectivist and positivist bases (Hansen, 2004). Positivist perspectives have been defined as theory putting forward a truth that is able to make accurate predictions. Burr (2003) argued that positivism assumes there is a concept of reality, and this is perceived as truth, allowing for reality to be objectively examined and understood (Denzin & Lincoln, 2000).

As the present research acknowledges the individuality surrounding clients' experiencing of being sexually attracted to children, a positivist perspective presented as problematic. Furthermore, it seemed immoral to be

assuming the presence of an objective truth that could be measured, when the data collected would be coming from a second-hand perspective (psychological professionals). Moreover, an objective position also makes large assumptions about the research process. It is thought variables such as perceptions, cultures, and social influences can be controlled for, limiting the impact on data collection. Undertaking work as a Trainee Counselling Psychologist has taught me to value the role social and cultural factors can have on an individual's perceptions (Health Professions Council, 2009: 3a.1), both in regards to clinical work and the research process. My training, and the importance I place on such factors, therefore made it difficult to incorporate a positivist or objectivist position, with the belief that social and cultural factors undoubtedly impact what individual's may find helpful in abstaining from their attraction to children.

Qualitative methodologies, however, aim to *"stress the socially constructed nature of reality, the intimate relationship between the research and what is studied, and the situational constraints that shape inquiry* (Denzin & Lincoln, 2003, pg.13)". Qualitative methodologies are argued to account for a multitude of perspectives, incorporating social and subjective meanings (Flick, 2011), when exploring social phenomena. Due to the convoluted and contested nature of terms, such as "paedophilia", used within the present research, and to explore the factors that could impact upon these terms within social experiencing, it appeared counterintuitive to utilise an objectivist approach that could further quantify behaviour rather than exploring the underlying dynamics of behaviour.

Qualitative research is thus more likely to utilise relativist positioning. A relativist position suggests that there is no one reality, with reality being constructed based upon one's individual perspectives. Burr (2003) proposed this approach allowed for an array of truths and realities based upon individual perceptions. The aims and objectives of the present research[12] therefore lent itself to the incorporation of a qualitative paradigm, accepting the existence of numerous truths and realities in psychological professionals' perceptions of what could help/hinder an individual to abstain from acting upon their attraction to children.

3.2 Ontological Positioning

Being aware of, and working in alignment with, one's ontological and epistemological position is of paramount importance to researchers. Ontology can be defined as the position from which an individual studies existence and being (Crotty, 1998); whereas epistemology can be understood as providing meaning to knowledge (ibid).

3.2.1 Researcher's positioning

As part of the research process and development as a Trainee Counselling Psychologist, I have reflected upon my ontological and epistemological positioning. Whilst considering my positioning, I noted my beliefs aligned with relativist ontology. I argue that my ontological position as relativist conflicts with

[12] Please refer to pg.52 in Chapter II for the aims and objectives of the present research.

an objectivist epistemological position. As the present research is interested in the unique experiences of each participant, in working with clients who identify as being sexually attracted to children, an objectivist position was rejected, therefore the choice of using a subjectivist, constructionist or a constructivist epistemological stance were considered.

3.3 Epistemological Positioning

3.3.1 Considering Interpretative Phenomenological Analysis

A subjectivist epistemological stance is commonly associated with the use of Interpretative Phenomenological Analysis (IPA). IPA aims to explore how individuals makes sense of their world through studying their subjective experiences; giving rise to the valuing of individual meaning making (Flick, 2011). When conducting this form of research, a researcher would aim to make sense of the individual's process of understanding their personal world. Through a process of bracketing, the researcher's perceptions are distinguished from that of the participant's subjective account, allowing for the development of an objective account for a given subjective experience (Crotty, 1998).

For the present research, IPA would have offered a way to explore how psychological professionals experience working with clients who identify as being sexually attracted to children. However, this would have placed a greater focus on the experiencing of the professional, rather than the client. As there is little-to-no literature in the UK on working with client's who are sexually

attracted to children, but have not acted upon their attraction, it was determined that a tentative explanatory framework would better serve Counselling Psychologists when working with this population. Since the attention of the present research is focused on what aids abstinence in this population, what processes are involved, and how this impacts the way clients are treated within psychological services, I considered that an IPA approach would not achieve the aims of the research.

3.3.2 Considering Grounded Theory

Unlike IPA, Grounded Theory (GT) does not commonly adopt a subjectivist epistemological stance, often adopting either a constructionist or constructivist position (Hall, Griffiths & McKenna, 2013; Ward, Hoare & Gott, 2015). It is hotly contested within the social sciences that there is little difference between a constructionist and constructivist epistemological stance (Greckhamer & Koro-Ljungberg, 2005; Mallon, 2008; Ward, Hoare & Gott, 2015). Both paradigms are argued to move from positivist ontology towards relativist ontology, contrasting the objectivist view that the world is measurable. While the difference between these two positions could be negligible, it is suggested to be pivotal to the overall focus and interpretation of the data (Crotty, 1998; Ward, Hoare & Gott, 2015).

A constructionist epistemological position suggests individuals create meanings and realities throughout their development in the social world. Meanings are formed through an individual's relationships with society which

subsequently influences their thoughts and behaviours (Burr, 2003; Charmaz, 2014; Crotty, 1998). Constructionism views truths and realities as social constructions, where experiences become meaningful due to the interactions an individual has with their social environment and context (Crotty, 1998).

Social constructionism challenges the premises of positivism through relativist epistemologies. Charmaz (2014) states, *"…instead of assuming realities in an external world – including global structures and local cultures – social constructionists study what people at a particular time and place take as real, how they construct their views and actions, when different constructions arise, whose constructions become taken as definitive, and how that process ensues"* (pg. 344). This perspective takes into account that perceptions and realities are formed through discourses with one's social environment, and are subject to change should that environment change. Thus implying that all social realities are constructed through the shared interactions and interpretations individuals make in their day-to-day lives (Crotty, 1998). This epistemological positioning presented as a suitable match for the present research, where is it acknowledged that the participant's perceptions could change depending upon the experiences they encounter, the clients they work with, and the stance of their organisation towards clients who are sexually attracted to children.

Constructivism similarly rejects the existence of an objective reality (Mills, Bonner & Francis, 2006), suggesting that, "…*realities are social constructions of the mind"* (Guba & Lincoln, 1989, pg.43) and only the number of individuals can limit the number of constructions. The epistemology of this

paradigm calls attention to the subjective interrelationship between the participant and the researcher, emphasising the co-construction of interpretation and meaning (Mills, Bonner & Francis, 2006; Pidgeon & Henwood, 1997). Constructivism puts emphasis on the individual and their process of meaning making in relation to a given phenomenon, turning the focus from social contexts to the individual. This epistemological position allows for the exploration of social perceptions towards individuals who are sexually attracted to children, while also accounting for individual factors that are potentially not determined by society. Constructivism "…*assumes that people, including researchers, construct the realities in which they participate"* (Charmaz, 2014 pg.187). It implies reality is the construction of the individual and their interactions with the world, placing a focus upon the individual's perceptions and cognitions towards a given phenomenon.

It could be argued that either constructionism or constructivism appear as suitable fits for the aims set out in the present research, focusing on what aids abstinence in client's who are sexually attracted to children (but have not acted on their attraction), what processes are involved during abstinence, and how this impacts the way clients are treated within psychological services. It was therefore decided that either a social constructionist or a constructivist epistemological position would be used within the present research.

3.3.3 Theoretical Perspective: Symbolic Interactionism

Symbolic interactionism is a fundamental aspect of GT, emphasising the value of the subjective meaning that an individual attaches to life experiences. Subjective meaning is thought to arise from the individual's relationship with others, developing their own identities and beliefs of the world (Goulding, 1999; Flick, 2011). Charmaz's (2006) perspective on symbolic interactionism describes how researchers are able to learn from the world, with emerging theories being based upon constructions of participants' experiences and interactions. This take on symbolic interactionism suggests meanings, perceptions and experiences collected from participants within the research are not an objective or all-encompassing view of the world, but rather a construction of a specific reality (Charmaz, 2006).

The present research strives to understand what could aid individuals, who are sexually attracted to children, to abstain from physical action. It is acknowledged that each participant's meaning and understandings are constructed, relative and unique. Symbolic interactionism results in the researcher exploring each participant's use of self and meanings as a process. This positioning presents as suitable for exploring how psychological professionals, working with potential offenders, presume certain factors carry meaning and effect towards the concept of abstinence. This meaning will arise out of the interactions between the participant and their clients, psychological professionals, and their underlying meanings and assumptions about sexual attraction and offending. These meanings are subject to change depending upon

the participant's ongoing experiences, for example the clients they will encounter.

3.4 Grounded Theory

The relationship between relativist ontology, a constructionist/constructivist epistemology and symbolic interactionism resulted in the consideration that using a GT methodology would be most appropriate. GT and symbolic interactionism equally emphasise the need to attend to the process occurring in the actions of discourse and meanings created. The debates between the different schools of GT are many and ongoing. While there is not scope within this research to explore this fully, the most frequently used permutations will be considered.

3.4.1 A Historical Perspective: Establishing Grounded Theory

When considering which school of GT to use it was important to consider the development and progression of this methodology. Glaser and Strauss (1967) first coined GT as an approach to overturn psychological research norms of quantitative and positivist paradigms; challenging the understanding that qualitative research could not provide as thorough an understanding of a phenomena as that of quantitative methodologies.

The mixing of pragmatist and positivist epistemologies (Bryant & Charmaz, 2007), led to the development of a rigorous coding method in which

qualitative data could be analysed and dissected. This approach also extended the focus to include symbolic interactionism (ibid). Glaser & Strauss (1967) postulated that GT facilitates the exploration of phenomena where theoretical understanding may be absent or sparse. This is particularly useful for the present research where there is little existing research on what impacts an individual's ability to abstain from acting upon their sexual attraction to children.

This traditional form of GT carries the assumption that researchers are able to adopt a stance of *tabular rasa* (blank slate), however, this has more recently been criticised as a naïve assumption (Clarke, 2005). It is now commonly accepted that a researcher would enter the research process with a prior interest impacting upon the collection and analysis of data (Ward, Hoare & Gott, 2015).

3.4.2 Schools of Grounded Theory

In 1978 Glaser adapted the traditional GT methodology, placing new roots within positivist ontology, searching for a truth that was deemed able to be found. Glaser shied away from pinning his permutation to a set of philosophies, stating that the incorporation of a philosophical position could alter the natural emergence of the GT (Glaser, 2005). As highlighted earlier within this chapter, positivism does not align with the stance of the present research, where it is assumed that there are numerous different realities as to what may benefit clients in abstaining from their sexual attraction to children.

In contrast, Strauss (1987) put forward a permutation stemming from relativist ontology. It was argued that *"…truth is enacted…"* (Strauss & Corbin, 1994, pg.279), and therefore will change from individual-to-individual, time-to-time and society-to-society. This is of particular interest to the present research where is acknowledged that the data collected is subject to societal norms and individual experiences encompassing the participants' experience of working with clients who are sexually attracted to children.

Strauss' permutation allowed for the existence of a multitude of truths. Furthermore, unlike the stance of *tabular rasa*, Strauss & Corbin (1998) argued that researchers are actively involved within data collection and analysis processes – combining their background, beliefs, and social interactions to form a unique integration that influences and alters what is attended to and the findings that emerge. As acknowledged within my reflexivity[13], my own stance towards this research will have undoubtedly impacted not only data collection but also the analysis. Therefore moving away from the stance of *tabular rasa* seemed important.

Charmaz (2000; 2006) further developed GT, introducing constructivist GT. Charmaz argued that the development of a theory is constructed by the interactions between researchers and participants. During the analysis stage, the researcher will analyse the data in accordance with the specific research context, resulting in a generalised sense of reality from the participant's individual

[13] Please refer to pg.16-18 in Chapter I for an exploration of my reflexivity prior to conducting the present research.

experiences. This is however only one reality that is put forward, Charmaz (2006) classified this as another constructed reality rather than an objective explanation. Constructivist GT maintains the rigour from traditional GT, whilst introducing the researcher to consider their reflexivity and understanding of the participant's world (ibid).

On reflection of the different ontological and epistemological stances behind each of the different schools of GT, it became apparent that choosing constructivist GT as put forward by Charmaz (2000; 2006) would be the appropriate choice. This decision was made based upon the added reflexivity, and clear alignment of epistemology and ontology with the research and a constructivist approach.

3.4.3 Constructivist Grounded Theory and the present research

The current research does not dispute the significance of societal context, and does not attempt to deny that much of an individual's meaning making process comes from their interactions with society. Due to this a 'social constructivism' approach was utilised. Social constructivism places an emphasis on the role of society and culture upon how an individual is able to construct knowledge and understanding in regards to a given phenomenon (Derry, 1999; Ward, Hoare & Gott, 2015).

3.4.3.1 Constructivist Grounded Theory and Lacking Literature

As stated throughout, there is a significant gap in the literature on paedophiles/hebephiles. GT is able to greatly contribute to fields and areas of interests where there is little known (Corbin & Strauss, 1998). The use of GT in the present research therefore not only hopes to provide a platform of understanding for clinicians wishing to work with clients who are sexually attracted to children (but have not acted), but also will act as a baseline for further investigation into the psychological treatment for this population.

When exploring some of the research outlined within the literature review (for example: Beier *et al.,* 2009b; Mann & Barnett, 2013; Neutze *et al.,* 2010), it was demonstrated that numerous factors including stigma, legislation and victim empathy could all influence an individual's likelihood to act upon their sexual attraction to children. The use of GT will be significant when considering the potential volume of factors that could impact this process, allowing for the inclusion of an unlimited number of factors that may impact an individual's ability to abstain from physically acting upon their sexual attraction to children.

3.4.3.2 Aligning with Counselling Psychology

Constructivist GT places the individual at the centre of the meaning making process, whilst continuing to acknowledge the role that society plays.

Whilst this approach has more commonly been utilised by Sociologists, it has grown increasingly popular in the field of Counselling Psychology.

Several studies conducted into sexual offending have shown that a Psychologist/Counsellor's attitude towards their client can impact upon the perceived success of treatment (Andrews & Bonta, 2006; Andrews & Downden, 2007). Research (for example: Jahnke, Imhoff & Hoyer, 2014) highlighted continued prejudice towards working with this population, with many psychological professionals arguing it is "taking the side of the offender". Furthermore, comparisons between UK and EU legislation highlight the discrepancies in how psychological professionals are able to treat individual's with sexual attraction towards children should they present for treatment (Beier *et al.,* 2009b; Schaefer *et al.,* 2010). These findings reflect the limited knowledge that many psychological professionals have towards working with individuals who are sexually attracted to children, simultaneously highlighting the need for greater research in this area.

The present study aimed, and anticipated, the production of knowledge that could be utilised by Counselling Psychology, furthering the field's understanding of how better to work with this population.

3.4.3.3 The Present Research

Constructivist GT takes into account the researcher's lived experience, experience of working with the subject matter, and any relevant theoretical

knowledge they may hold. This occurs through the assumption that the data is generated via interactions *between* the researcher and the participant during the data collection, transcribing and analysis processes (Lincoln & Denzin, 2005). Thus, the emerging theoretical explanation is a *mutual* construction of knowledge between the researcher and the participants (Charmaz, 2000).

Constructivist GT also focuses on the macroscopic contextual issues surrounding the research phenomena (Charmaz, 2006; Strauss & Corbin, 1998). Due to this, this methodology is well suited for exploring, through the therapists' perspectives, the context of sexual offending and social pressures to conform to a 'sexual norm'. Through accounting for the issues raised within the literature review, whilst exploring the experiences of working with individual's who wish to abstain from acting upon their sexual attraction to children, this methodology will allow for an all-inclusive understanding as to what could aid abstinence for these individuals.

Within the present research, I aimed to represent the realities of all participants involved, transforming their experiences into a unifying representation. I acknowledge that this can only be one representation, of which many are possible, and therefore is not an overarching universal truth. In line with Bryant & Charmaz (2007) the present research aimed to produce tentative generalisations, which are limited to the data collected, rather than producing a universal statement which could be applied to all individuals who may wish to abstain from physically acting upon their attraction to children.

3.4.3.4 Answering the Research Question

The majority of studies conducted around potential offenders have been conducted on a sample of CSO (McGrath *et al.,* 2013; Neutze *et al.,* 2010; Schmidt *et al.*, 2013). Freeman-Longo and Blanchard (1998) argued that a fresh perspective is required, moving towards prevention, if CSA is to reduce. However, little has been done to bridge the ever-growing gap in psychological professionals knowledge on how best to work with, and aid, individuals who wish to abstain from acting upon their attraction towards children.

While a new wave of research is being conducted in Germany (Beier *et al.,* 2009a; 2009b; Van Horn *et al.,* 2015), through the establishment of PPD[14], research to date has focused on how best to access and entice potential offenders into treatment. Attempts to understand what impacts an individual's decision, and ability, to refrain from acting upon their attraction towards children remains missing from the literature. One of this research's aims is to explore psychological professionals experiences of what appears to help/hinder clients ability to abstain from acting upon their attraction to children. The study will undoubtedly explore some of the issues described by the PPD team, including the impact of stigma and legislation. It is hoped that the findings will contribute to the inadequate understanding of facilitating abstinence within clients who are attracted to children.

[14] Please refer to p.36-37 in Chapter II which refer to PPD specifically

Charmaz (2006) argued that, "*a finished GT explains the studies process in new theoretical terms, explicates the properties of the theoretical categories, and often demonstrates the causes and conditions under which the process emerges and varies, and delineates its consequences*" (pg. 7-8). The present research aimed to construct a final GT through the exploration of psychological professionals experiences of working with clients who self-identify as being sexually attracted to children. The resulting knowledge hoped to explain numerous facets about clients' experiences, exploring the process from deciding to disclose their sexual attraction through to receiving psychological support, offering a tentative framework of possible factors that help/hinder a client's ability to refrain from acting upon their attraction to children.

3.5 Role of the Researcher

It is acknowledged that my relationship, as the researcher, impacted how the findings were interpreted (Denzin & Lincoln, 2003). Illuminating any potential researcher bias is essential within qualitative methodologies. While biases have traditionally be suggested to have negative consequences in research, it could also be argued that the subjective value a researcher holds towards a phenomena highlights their compassionate insights and empathic understanding (Moustakas, 1990). In line with one of the core relational principles in Counselling Psychology:

> "To know empathically and to respect first person accounts as valid in their own terms; to elucidate, interpret and negotiate between perceptions and world

views but not to assume the automatic superiority of any one way of experiencing, feeling, valuing and knowing."

(Division of Counselling Psychology, BPS, 2005, pg.1)

Therefore I suggest the researcher *should* hold a subjective interest in the area of study, allowing for the presence of genuine empathy towards participants and their accounts. This steps away from objective and positivist positions, privileging the unique subjective experience and understanding over the search for a universal truth.

3.6 Summary

This chapter has explored the processes in determining constructivist GT for the present research. It has begun the exploration of how GT methods will enable to research to meet the aims and objectives as set out in Chapter II[15]. The next chapter describes the GT methods that were implemented throughout data collection and analysis in order to achieve the research aims.

[15] Please refer to pg.52 in the Chapter II for the aims and objectives.

Chapter IV: Method

GT, like other qualitative methodologies, utilises a framework for viewing and analysing, aiming to generate a theory to further the understanding of the given phenomenon (Charmaz, 2006; Strauss & Corbin, 1998). Unlike other approaches, GT generates theories that are grounded within data collected (Charmaz, 2006). After deciding upon using a Constructivist GT approach, I followed the method detailed by Charmaz (2006) during data collection and analysis. However, this method was used as a flexible guideline rather than a rigid structure. The procedures followed during data collection and analysis are detailed within this chapter.

4.1 Sampling

The present research initially aimed to recruit eight to ten participants[16], all of whom had worked with at least one client who self-identified as being sexually attracted to children. In order to achieve an effective sampling procedure all recruitment emails and techniques were "*targeted and efficient*" (Morse, 2007 pg.233). Convenience sampling was utilised, identifying individuals who have encountered the phenomenon being explored: working with individuals who are sexually attracted to children, but have not acted upon their attraction.

[16] The final sample size was based upon theoretical saturation.

4.1.1 Inclusion Criteria

The selection criteria were as follows:

- To be registered *and* accredited to at least one of the following professional bodies: BPS, BACP, BABCP, COSRT, HCPC and/or UKCP.
- To have worked with *at least* one client, over the age of 18, who self-identified as being sexually attracted to children (under the age of 16).
- For the client in question to *have not* acted upon their sexual attraction, to the best of the therapist's knowledge.
- To have worked with the client in a therapeutic context: either one-to-one or in a therapeutic group.

4.2 Recruitment

4.2.1 Recruitment Procedure

During the initial stages of recruitment an email[17] containing the Participant Information Sheet[18] was sent to organisations and charities that could have worked with individuals who identify as being attracted to children. These organisations included LFF, StopSO, Circles, Relate, Richmond Fellowship, The Philadelphia Association, and UK branches of Mind. E-mails and telephone calls were also made to the NHS Portman Clinic who specialise in working with clients who suffer from delinquent and criminal behaviours.

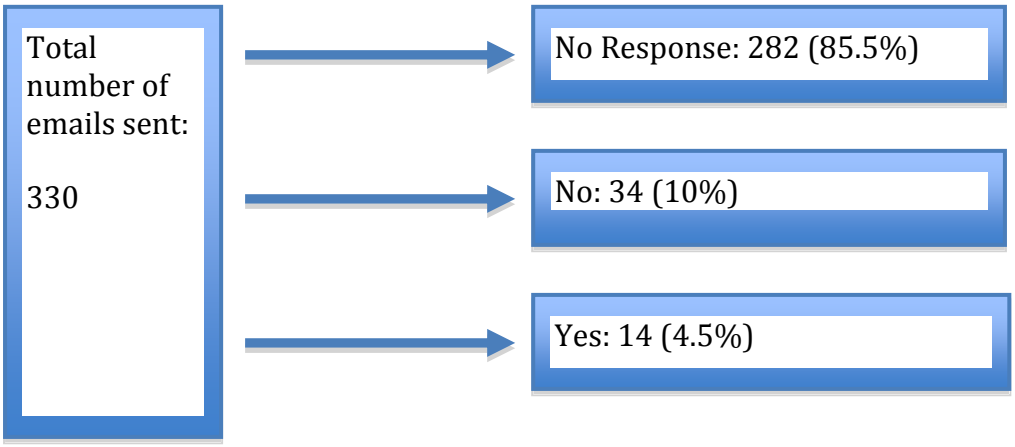
[17] Please refer to Appendix 4 pg.211 for the recruitment email

[18] Please refer to Appendix 5 pg.212 for the participant information sheet

The majority of the organisations responded stating that my request would be cascaded to their members, who would then be asked to contact me directly should they wish to be involved. Because of this, I am unaware of the number of individuals who received my e-mail. Unfortunately, I did not hear back from either Relate or the Portman Clinic during the time set aside for recruitment. E-mail responses were received from branches of Mind, Circles, Philadelphia Association, and the Richmond Fellowship stating that the services were either closing, had limited staff who did not meet the inclusion criteria of the research, or unfortunately no longer had the means to take part in research. I received one respondent from LFF and two from StopSO.

E-mails were also sent to individuals listed on the UKCP, BPS, BACP and COSRT websites who affiliated themselves as working with clients who presented with sexual issues, sexual identity, and/or sexual addiction. In total 330 recruitment emails (excluding those cascaded internally by organisations) were sent. A breakdown of the responses is provided in Figure 1.1.

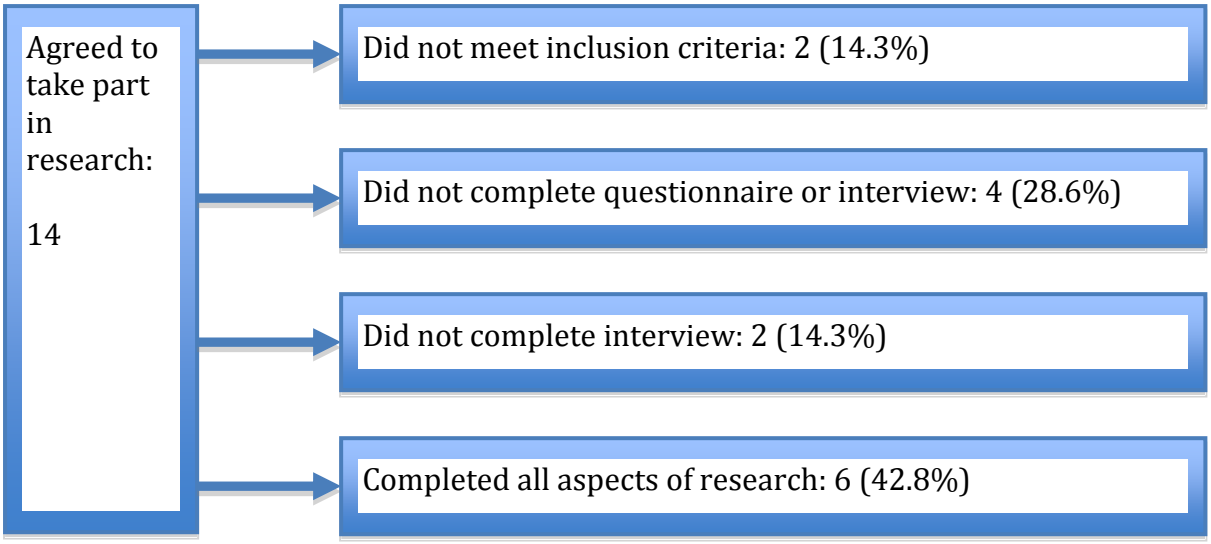
Figure 1.1 Breakdown of total responses:



Upon receiving notice that an individual was interested in taking part in the research, a demographics questionnaire[19] was e-mailed to potential participants. The questionnaire ensured that participants met the inclusion criteria as well as providing demographic details that allowed for a comparison between participant backgrounds. Figure 1.2 details the ongoing sampling process, with a final total of six participants being recruited.

[19] Please refer to Appendix 6 pg.215 for the demographic questionnaire.

Figure 1.2 Breakdown of participants agreeing to take part in the research:



4.2.2 Participants

In order to protect the participants confidentiality pseudonyms have been used. Two of the participants did not complete all of the requirements for the research; both completed the questionnaire only. While attempts were made to contact the participants and reschedule the interviews, neither made any further contact. As the participants did not request to withdraw their data, their demographic information has been displayed below (Table 4.1). Their data has been used to show the spread of professionals working with clients who express being attracted to children.

Table 4.1 Participant demographics

Name[20]	Gender	Year of Qualification	Occupation	Professional Body Membership	Preferred Therapeutic Model	Place of Practice	Number of clients seen with this presenting difficulty	Minimum number of sessions completed	Maximum number of sessions completed	Interview
Sophia	Female	2002	Forensic Psychologist	HCPC BPS	CBT	Charity	100 +	1	85 +	Yes
Ben	Male	1998	Psychologist	BACP UKCP	Integrative Psychosynthesis	Private practice	30 +	4	150 +	Yes
Fiona	Female	1996	Psychotherapist	COSRT	Integrative CBT	Private practice	3	2	20+	Yes
Oliver	Male	2003	Clinical Psychologist	HCPC BPS BABCP	Integrative CBT	NHS	10 +	2	30 +	Yes
Sharon	Female	1994	Psychotherapist	UKCP	Integrative CBT	Private practice	9	7	12 +	Yes
Jennifer	Female	2014	Counselling Psychologist	HCPC BPS BACP	Psychodynamic Psychoanalytic Integrative	NHS & Private practice	3	18	21+	Yes
Rachel	Female	1984	Psychotherapist	COSRT	Integrative	Private practice	24	12	40 +	No
George	Male	1997	Psychotherapist	BACP	Technical Eclecticism	Private practice	50 +	1	200 +	No

[20] Pseudonyms have been used to protect participants' anonymity.

4.3 Ethical Consideration

4.3.1 Ethical Considerations for Participants

Ethical approval was sought and gained prior to conducting the present research from the University of Roehampton's Research Committee[21]. Similar research, using psychological professionals as the participants, had no record of adverse effects; there was no reason to believe that the present research would cause harm. Participants were made aware that it was a sensitive topic that would be being discussed, however, as all of the participants worked within this area it was expected that none would be adversely affected. None of the participants reported feeling distressed during or after the completion of the interview.

All participants were informed both verbally and in writing that their participation was voluntary and they had the right to withdraw at any point, without needing to provide a reason. Participants were made aware that there were limits to confidentiality, but that every step would be taken to maintain their anonymity (e.g. the use of pseudonyms). Participants were informed that the present research could be published, and data would be kept for a period of ten years on a password-protected hard drive only accessible by the researcher. The period of time data will be stored is also in accordance with University regulations.

[21] Please refer to Appendix 7 pg.217 for ethical approval for the present research.

Consent forms[22] that included the participant's name and signature were stored separately from any other data. Participants signed two consent forms; one copy remained with the participant while I, as the researcher, kept the other. Each participant was provided with an identification number that corresponded to their consent form, demographic questionnaire as well as their raw and processed data. This identification number was stored in a separate password protected file.

4.3.2 Ethical Considerations for Researcher

As the interviews were conducted away from the University of Roehampton campus, the University's Lone Worker Policy was adhered to. An arrangement was made where a member of my immediate family would be contacted before and immediately after each off-site interview.

4.4 Design

4.4.1 Data Collection

Data collection was completed through two different avenues: the demographic questionnaire and semi-structured interviews. The interview comprised open-ended questions aimed at eliciting insight into participant's experience of working with clients who self-identify as being sexually attracted to children. The interview schedule acted as a guide, allowing the order of the

[22] Please refer to Appendix 8 pg.219 for the participant consent form.

questions to vary depending upon the data provided by each participant. These questions covered areas such as the participant's experience, impact of the therapeutic relationship, and the impact of society/social support.

4.4.2 Interview Procedure

4.4.2.1 Pilot

Grounded theorists warn against assuming that a researcher's perceived skills are sufficient for yielding rich data within an interview (Birks & Mills, 2011). While I had confidence in my ability to effectively communicate, establish a rapport and explore concepts at depth with participants, I did not assume that this would be all that was necessary in order to collect a wealth of data. To better prepare for the research a pilot interview was conducted with a peer who had knowledge of the area of exploration. The pilot study mirrored the steps that would be taken within the research. After receiving constructive feedback from my peer, adaptations and improvements were made to the interview schedule.

4.4.2.2 Interviewing in GT

In line with the work by Charmaz (2001; 2006) and the principles of constructivist GT, questions within the interview were open-ended and subject to slight alterations. This allowed for the process of micro questioning where emergent themes, and common codes, from previous interviews can be explored in subsequent interviews. Through micro questioning and focusing within

interviews, the range of topics covered narrows allowing for the collection of *specific* and *relevant* data for the developing theory. Charmaz (2006) argued this flexibility in altering the focus if necessary, while providing an emerging shape to the data, meets the aims of GT research where the emergent theory is grounded within the data.

4.4.2.3 Interview Protocol

Upon determining a participant was suitable for the research, a date, time and location for the interview was scheduled. The participants were informed the interviews could be conducted at either their place of work, at the University of Roehampton or Skype. Each participant was informed that the interviews could last up to 90 minutes. The interviews ranged from 54 to 85 minutes in length and were audio-recorded. After completion each participant was provided with a debriefing form[23]. The debriefing form reiterated the purpose of the research and reminded the participant of their right to confidentiality and ability to withdraw from the research at any point.

The interviews adopted a semi-structured format, allowing for the questioning to follow the participant's conversation while acting as a prompt and guide (Birks & Mills, 2011) should the conversation deviate away from the research aims. Opening questions were designed to provide context for the experiences the participant would be sharing. Following questions focused on the role of different factors, and how, if at all, these were incorporated into the

[23] Please refer to Appendix 9 pg.222 for the participant debrief form

work a participant completes with their client. Closing questions provided the participant with the opportunity to explore any areas they thought were absent in the interview. All questions were followed by reflections encouraging the participant to expand further, whilst also checking for accuracy in understanding. All responses made by participants were treated with respect.

The following are a list of example open-ended questions used within the research:

- ***For me to understand what it is you will be sharing today, I was wondering if you could tell me about the context and experience that you have?***

- ***Is there a specific way of working with this client group that you use?***

- ***Could you elaborate on some of the therapeutic techniques/areas you would usually cover in your work with these clients?***

- ***Is there anything from this form of work that the clients' have reported as being of beneficial in their ability to abstain from acting upon their sexual attraction?***

Only example questions are provided above as the interview questions were modified throughout data collection dependent upon the previous interviews conducted, data analysis and emerging codes (Birks & Mills, 2011).

The questions listed display some of the initial interview questions that were formed before data collection had begun. The questions aimed to incorporate symbolic interactionism, in the hope of eliciting data that demonstrates the experiences and perspectives of participants towards working with individuals who expressed being attracted to children. It was hoped this would aid in the learning of this little-known area (Charmaz, 2006).

As the interviews were conducted, it was noted that participant discourse went beyond the remit of the initial interview questions, delving into richer subject grounds. For example, through the course of the interviews, areas such as stigma, the impact of regulations on both the participant and their clients, and the need for hope all arose. It was interesting to witness the co-construction occurring between myself and participants, building a joint understanding of what could help/hinder paedophiles/hebephiles, in a space where there was a freedom to explore the areas designated as important to participants, without a need to strictly adhere to the initial interview questions.

Through the process of micro-questioning areas of interest mentioned by participants, that were absent from the initial interview questions, could be explored at depth. During this process the participants' individual meaning making processes and beliefs were explored, providing a wealth of understanding towards areas previously unexplored by the present and existing research. The final data collected moved away from the specific impact of therapy, the type of therapy conducted and the way of working therapeutically with this client group to a more encompassing view of the client's journey from

disclosing a sexual attraction to children to the potential consequences that could follow. Through moving beyond the remit of the initial interview questions, the tentative framework provided in the final GT was able to offer an explanation to the previously unknown processes facing this client group. The final GT is explored in depth over the course of the next two chapters.

4.4.3 Transcribing

After the completion of each interview the audio recording was transferred to a computer file and labelled using the participant's unique identifying number, and then deleted from the recording device. This file was stored separately from other files and was password protected. Each interview was transcribed with initial memos made throughout alongside arising ideas and potential codes for the overall theoretical model. These were all recorded and explored prior to conducting the next interview. During the transcription process, the interview was transcribed verbatim, with identifiable names and places being pseudonymed in order to maintain the client's anonymity if desired.

4.4.4 Pseudonyms

The renaming of clients through the use of pseudonyms proved an interesting challenge. I considered the importance of the name aligning with the participant's cultural, social and economic background. This became challenging as I had not collected the ethnicity of the participants. Due to this, I selected names based upon those that appeared to best fit the character of the

participant. The full list of pseudonyms chosen can be seen in Table 4.1[24]. Similarly locations, and other identifiable information that were altered to maintain anonymity, were provided with replacements that engendered similar cultural and socioeconomic connotations.

4.5 Data Analysis

4.5.1 Read, Listen, Repeat

In order to immerse myself within the analytical process, each transcript was reread numerous times. The audio recording of each interview was listened to repeatedly to gain insight into the participant's choice of wording and tone of voice. Each time the transcripts were re-read all levels of coding were reconsidered. This process was completed to enable the most accurate reflection of client's meanings to be generated, ensuring any subsequent codes would be grounded in the participant's language (Charmaz, 2006).

4.5.2 Analysis in Constructivist Grounded Theory

When analysing using a constructivist GT methodology, a focus is placed upon exploring and defining the data that has been generated. Raw data is broken down and transformed into distinct categories, which when combined, provide an insight into the phenomenon being explored. For the present research, it was hoped the categories would aid in learning what impacts an

[24] Please refer to pg.78 for Table 4.1 containing participant pseudonyms.

individual's decision to not act upon their attraction to children. As outlined by Charmaz (2006) this form of analysis incorporates memoing, coding, integration, diagrams and theoretical formation. During this process of analysis many processes occur concurrently (Birks & Mills, 2011). Rather than a linear process where data collection would be followed by analysis, in GT it is common for the two to occur together. This section illustrates the different aspects of analysis, and how each of these was implemented concurrently. A diagram (figure 4.1) depicting the analytical process is displayed below.

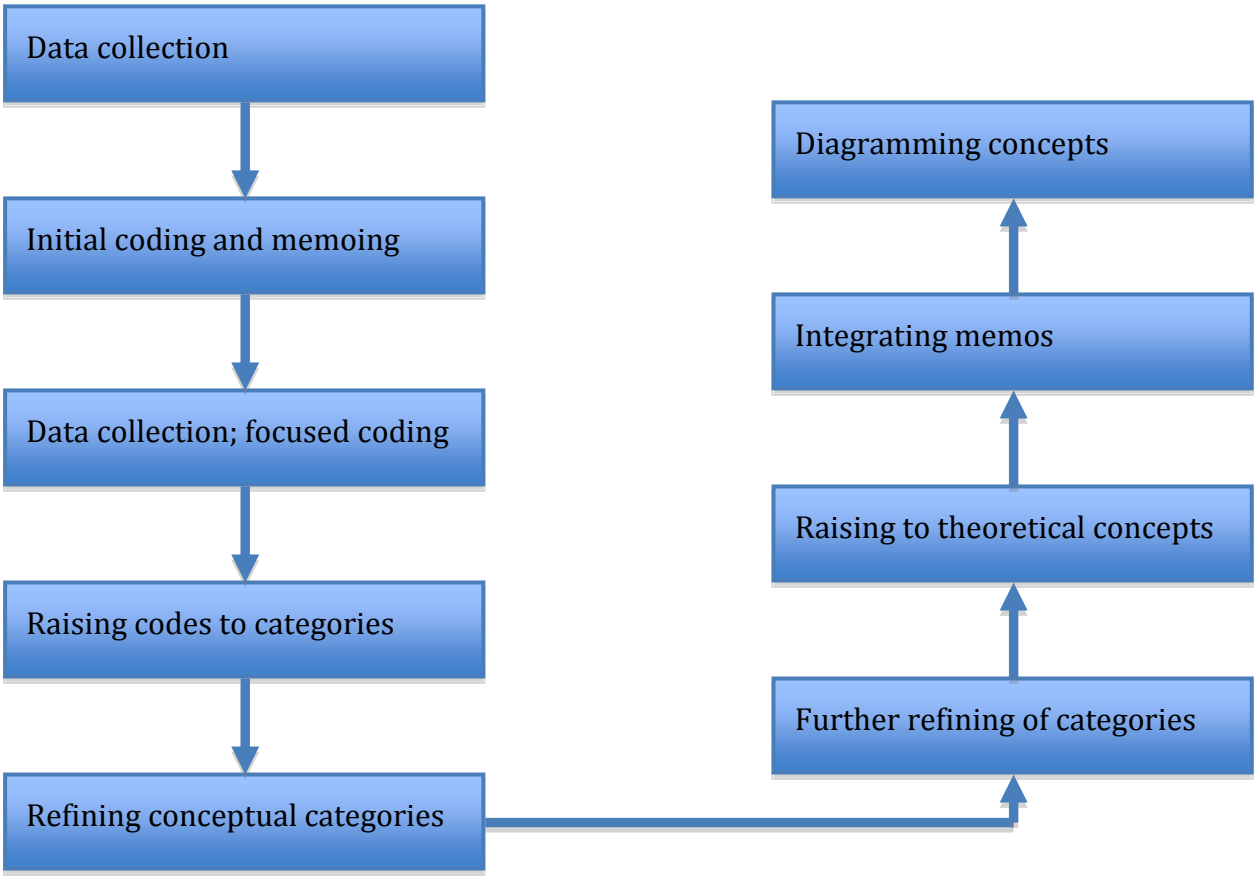


Figure 4.1 The analytical process

4.5.3 Memoing, Diagramming and In Vivo Codes

Completed in conjunction with the coding process, memoing or memo writing, is considered essential within GT methods (Glaser, 1998), accounting for the earliest stages of analysing and incorporating initial ideas and thoughts of the researcher. The process of memoing highlighted numerous codes that could have had importance towards the building of theoretical codes (Charmaz, 2006), as well as exploring the analytic properties within the codes and patterns that were being generated in the data (Charmaz, 2006; Strauss & Glaser, 1970). Memoing commenced during the first review of the audio-recordings, and continued throughout the process of rereading transcripts and coding. This process started the continuing comparisons between data sets and emerging codes.

Diagramming in constructivist GT is considered pivotal in connecting categories together (Mills, Bonner & Francis, 2006). Diagramming is used to compare emerging relationships between theoretical codes, alluding to a provisional structure for the rising GT. Within the present study diagramming provided a visual observation of relationships forming between theoretical categories and sub-categories. The theoretical codes were grouped and linked to sub-categories, determining its value and relevance. Each of the sub-categories were also linked to one overarching category depicting the emerging GT. The process of diagramming was continuous throughout the analytical process, and

continued until the final GT was established. Examples of diagramming can be seen in Chapter V. [25]

In vivo coding extracts specific words and quotes that present as significant. This process preserves specific terms used by participants, providing another means by which the developing theory remains grounded within the data (Charmaz, 2006). In vivo codes reflected meanings, thoughts and perceptions of the participants, adding support to the developing initial, focused and theoretical codes, through considering their social world (Morrill, 1995).

4.5.4 Initial Coding

Once the collection of data and transcribing started, the first coding step (alongside memoing) is initial coding[26]. Initial codes closely align with the data, focusing on what the participant is "doing" with their choice of wording. During initial coding, Charmaz (2006, p.47) suggests that certain questions should be asked of the data. These questions are:

- *What is the data a study of?*
- *What does the data suggest?*
- *From whose point of view is it suggested?*
- *What theoretical category does this specific datum indicate?*

[25] Please refer to pages 98, 102, 110, 120, and 130 for diagramming within Chapter V.

[26] Please refer to Appendix 20, pg.235, for a full transcript with initial coding and memoing

Initial codes were constructed through going through each transcript line-by-line. The meanings behind words, statements, sentences and paragraphs were noted within each segment to provide clarification and give accuracy to the developing codes. Charmaz (2003) suggests line-by-line coding aids the researcher in distancing themselves from contaminating the data with their own motives, focusing instead on the intentions of the participant in that given moment. The participant's use of language, and its performative nature (Burr, 2003) were also taken into consideration.

4.5.5 Focus Coding

Focused coding expands upon initial coding by exploring and integrating the most significant initial codes. Focused codes are more selective, raising the codes to a conceptual level, tentatively explaining the phenomenon being explored (Glaser, 1978). This began the first stage of synthesising and organising the data generated from the interviews (Charmaz, 2006). The impact of the researcher was continually explored throughout the development of focused codes; it was acknowledged that the underlying meanings being generated from the data were due to co-constructions between the participant and myself (Charmaz, 1995). An example of transforming initial codes into focused codes from the present research can be seen within Table 4.2[27].

[27] Please also refer to Appendix 21, pg.305, for an example of focused coding alongside a transcript from the present research.

Table 4.2 Example focused Codes

Initial Codes from Interview 1	Tentative focused code
Needing long term holding	
Time as a limitation	Rome wasn't built in a day
A waiting game for change	
Initial Codes from Interview 2	**Tentative focused code**
Society pouring fuel on the fire	
Building schools of crime	Turning people into monsters
Encompassing social loathing	
Initial Codes from Interview 3	**Tentative focused code**
Needing to humanise the dehumanised	
Fighting against the tide	Fighting against the tide
Witnessing acting out of personal prejudice	

Continual comparisons between transcripts were conducted in keeping with GT (Charmaz, 2006). This process explored the sufficiency of the codes in explaining the research question: "what factors, if any, are perceived to impact upon an individual's decision to abstain from acting upon their sexual attraction towards children". This comparison resulted in the emergence of a series of tentative categories, questioning and solidifying the relationship between

different codes, enhancing the formation of a conceptual understanding (ibid). An example of focused codes forming tentative categories from the present research can be seen within Table 4.3.

Table 4.3 Raising focused codes to tentative categories

Focused codes from interview 1	**Focused codes from interview 2**	**Tentative categories**
Clients morphing into the social definition of paedophilia	*"I don't think anybody is naturally a paedophile"*	Transforming individuals into monsters
Clients seen as untouchable damaged goods	Organisations nervous to commit to client group	"The Untouchables", being unwanted by therapeutic services
Looking to therapy as an escape from trouble	Clients taking a chance on a better life	Clients placing their trust in therapists
Wanting to conform to the socially determined norms	Moving away from the monster within	Removing the demonising label

4.5.6 Theoretical Coding

Theoretical coding is the final stage in GT analysis. This process aims to provide secure and precise relationships between the most significant categories and sub-categories (Charmaz, 2006). As in other stages, comparisons were made between the different data sets, establishing similarities and differences that aid in the formation of a tentative theoretical explanation (Glaser & Strauss, 1967). Continual comparisons remove redundant or irrelevant codes once saturation of a category has occurred (Holton, 2007).

Theoretical coding adds understanding, coherence, and narrative to the categories through integrating focused codes, transforming the unfolding story into a tentative theory (Glaser, 1992). This occurs through forming specific conditions, and/or contexts, which occur throughout the data, highlighting the consequences of certain actions, changes and processes (Birks & Mills, 2011; Charmaz, 2006). The theoretical codes within this study were compared with diagrams and memos from early stages of analysis. This comparison ensured that the participant's perceptions were being accurately captured within the developing subcategories and overarching categories. An example of focussed codes being tentatively integrated into a theoretical code is captured within Table 4.4.

Table 4.4 Focused Codes within Theoretical Category 1

Category 1: Stepping out from the shadows	
Participants	**Focused Codes**
P1 Sophia	• Seeing the individual aside from offence. • Clients waiting to be tripped up. • Having complete transparency with clients.
P2 Ben	• Clients unravelling in therapy. • Enabling client's to step out from the shadow of their sexual attraction – *"it helps them to feel seen"* • Clients visualising themselves as part of society.
P3 Fiona	• Individual's exploding into services. • Clients moving out from the shadows. • Having a monster lurking in the dark.
P4 Oliver	• Gifting clients with their release. • Clients stopping hiding away from fantasy.
P5 Annette	• Clients daring to speak. • Client's building the courage to confide. • Hiding behind a façade in therapy.
P6 Jennifer	• Unleashing the truth in therapy. • Dropping disclosures into therapeutic sessions. • Sussing out therapist prior to disclosure.

4.5.6.1 Saturation

When using GT methods it is suggested that data gathering should only stop once theoretical saturation occurs. Glaser (2001) argued at this point the main categories have enough strength to support the developed GT. Charmaz (2006) suggested that saturation could be determined when new data no longer provided any new theoretical insights towards the overarching categories. However, due to limitations in recruitment, the process of theoretical saturation occurred less organically, therefore saturation was determined when continual comparisons no longer generated new codes (Glaser, 2001), and further comparisons were not warranted. When acknowledging the small sample size it was deemed suitable to have achieved sufficient saturation at this point within the analysis (Charmaz, 2006), with the acceptance that the theory may be subject to modification if further research were to be conducted.

4.6 Summary

This chapter has outlined the methods undertaken during analysis in order to examine the research aims[28]. It has demonstrated the processes completed, accompanied by examples of the data from each step of the analytic process. The following chapter will explore the findings from the present research.

[28] Please refer to pg.53 within Chapter II for the aims and objectives of the present research

Chapter V: Analysis

5.1 Introduction

Chapter five illustrates how constructivist GT methods were used to form a theoretical framework of what impacts the decision of abstinence in clients who self-identify as being sexually attracted to children. The use, and meaning, of 'theory' and 'theoretical framework' has often varied amongst theorists depending upon their epistemological and philosophical stances (Birks & Mills, 2011). In the present research, these terms are used to describe the process of integrating concepts and categories together in order to further knowledge about this specific phenomenon. This research uses the perspective from symbolic interactionism towards defining theory: aiming to improve understanding through an original contribution to a subject area (Charmaz, 2006). The final GT provides a tentative explanatory framework for how meanings and actions are derived from social and individual constructions, arising from the data through the interlinking of emerging codes to form four main categories.

5.2 Summary of findings

A tension exists between the societal expectation for paedophiles/hebephiles to conform to social standards and society's willingness to help. The role of therapist appears to be of paramount importance in

empowering change; however, therapists are embedded within society's construction of demonising the sexualisation of children. Furthermore, it was noticed that both the client and the therapist approach therapy under the premise that the client is there to undergo a process of change, stepping away from their attraction to children to align with societal norms.

Participants within this study all acknowledged the stigma clients, who are attracted to children, face every day from media headlines to fearing vigilante justice. The findings show that therapy was conducted through a discourse of hope and a promotion of change. What emerges from this research is the conflict of needing to align oneself and one's client, within society, whilst also needing to break down the socially constructed stigma engulfing individuals who display paedophilic/hebephilic tendencies.

A visual depiction of the final GT, 'Being in no-man's land: Punish first, treat second', is displayed below (figure 5.1), illustrating the core theme, major categories, and sub-categories, which constitute the GT. The diagrammatic version of the final GT depicts 'being left in no man's land: Punish first, treat second' as the intersection to all of the four major categories. It is, however, noted that the clients are likely to be engaging in a sense of 'being in no-man's land' before considering disclosing their sexual attraction to children, and thus the entire final GT is set within a sphere of 'being in no-man's land'. The diagram below serves to depict how the categories feed into the intersection of 'being left in no-man's land: punish first, treat second', as well as being stand alone experiences the participants described clients experiencing.

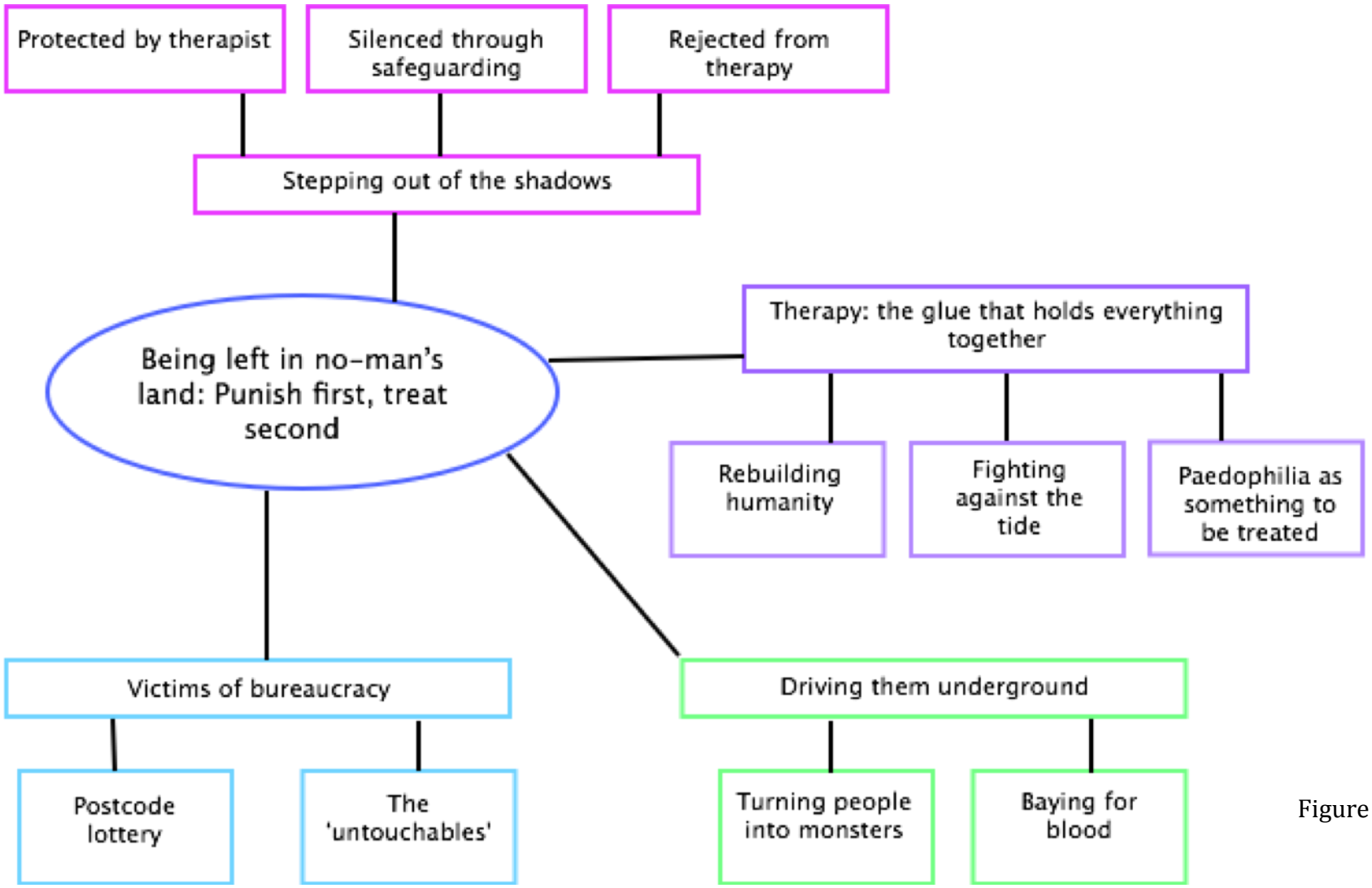


Figure 5.1 The final GT

To set the foundation for this chapter, a concise overview of the four categories and the relationship between these categories is explored. The four categories are:

- 'Stepping out from the shadows'
- 'Driving people underground'
- 'Victims of bureaucracy'
- 'Therapy: the glue that holds everything together'

These categories represent the principal themes that describe and account for the final GT. Category one reflects how participants have experienced disclosures of sexual attraction towards children within their therapeutic roles. This category describes the change in the disclosure process due to the interplay of internal and external factors. The negotiation of disclosure within the therapeutic environment appeared interrelated to clients' experiencing of society, social norms and experiences of engaging with statutory organisations, the themes comprising categories two and three respectively. Witnessing the dynamic interplay of clients' experiences with disclosure, bureaucratic procedures and social views shaped the participants' views on the impact of therapeutic support for their clients. The ways in which the social, political and organisational experiences are negotiated within therapy are included in category four.

Underlying the four main categories was a process of negotiation accounting for changes in the participants and clients' actions, behaviours and feelings throughout their therapeutic encounter. The category of 'therapy: the

glue that holds everything together' was further divided into three sub-categories. The three sub-categories include aspects relating to: rebuilding the client towards conforming to social norms, exploring the role support networks can have, contemplating the benefit of protecting through confinement, the struggle that therapists can face when working with clients who identify as being attracted to children and the treatments offered to this population. It accounts for the views of other European countries, changing societal views, and the therapeutic time offered to clients.

The final GT emerged as a result of interrelating the four main categories and respective sub-categories together, and is described as "Being left in no-mans land: Punish first, treat second". This is constructed within a sphere of overcoming social controversy and bureaucratic hurdles, in order for clients to achieve their desired state of abstaining from their attraction towards children.

The following section of this chapter depicts the emerging of the four categories. Each category will be individually represented combined with supporting evidence of extracts from the raw data. Finally, in accordance with the methods and methodologies used within GT, an ongoing comparison and integration between the four categories and the existing literature will be provided (Charmaz, 2006).

5.3 Four major categories

The four prominent categories emerging from the data are: 'stepping out from the shadows', 'driving them underground', 'victims of bureaucracy' and 'therapy: the glue that holds everything together'. Each of these categories took shape during the initial analysis, and grew in strength until theoretical saturation highlighted these categories as the principle accounts for the final GT (Birks & Mills, 2011; Charmaz, 2006). Each category is explored in turn beneath with a diagram to form a visual summary of the category, its sub-categories and any further theoretical codes and properties attached. The emergent theoretical codes demonstrate relationships between the different sub-categories; this process allowed for developing the main category towards an overarching theoretical direction, raising the categories into theoretical concepts (Charmaz, 2006)

5.4 Category one: 'Stepping out from the shadows'

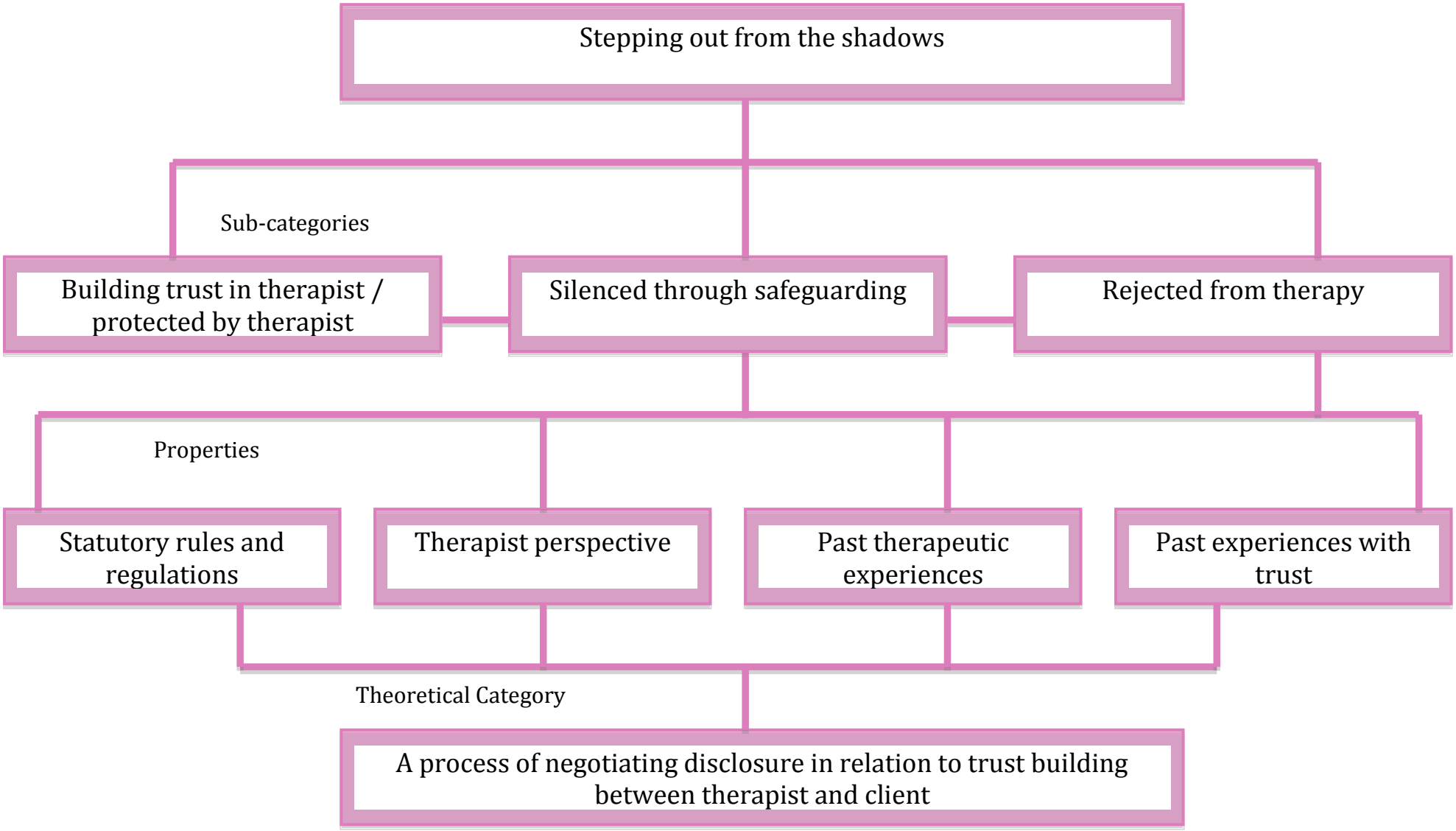


Figure 5.2 Category One

Category one (Figure 5.2) represents the participant's experiences of encountering disclosures of sexual attraction to children. Disclosures were initially explored to determine whether this client population were voluntarily seeking therapeutic support, or whether they had been directed to therapeutic support. However, after coding the first few interviews it became apparent other elements such as availability of therapeutic support, awareness of attraction, current social climate and involvement of government agencies were all connected to the perception of why a client would, or would not, choose to disclose their attraction. Taking into account that the first participant worked specifically for an organisation for potential offenders, I decided to explore these issues in greater depth. Over the course of the interviews it became apparent that the reasons for disclosure went beyond what I initially saw as a process in accessing the gateway to therapeutic support.

The extracts below demonstrate how the participants have experienced disclosure, and their perceptions of client's negotiating the fear of disclosure. The first extracts detail the relationship of trust and disclosure:

P1 Sophia

"I think they still have a, I suppose, a doubt in their mind as to whether we are really anonymous. You know they have to take our word on the fact that we don't trace their calls, other help lines would trace the call – but we don't. And I never know how many new people really want to call but just aren't able to trust as it's too scary"

P2 Ben

"It may take a long time for them to even speak about it. So you know, hardly anybody is going to come and see you for six weeks and say, 'by the way I would just like to tell you about this'. Especially unless they have been sent by a court or something. But if somebody is going to disclose this it is probably going to take them a year"

P6 Jennifer

"I think he had cased it out. He had worked it out by the time it came to the tenth session, that he could actually say it (…)[29] then he realised at some point in the therapy that he needed to, and that he wanted to"

These extracts highlight the construction of trust as a determinant in whether a client is willing and able to disclose their attraction to children. Moreover, as both Jennifer and Ben state, unless the decision to disclose has been taken out of the clients hands, it is likely to take the client a substantial amount of time to trust the therapeutic relationship enough to "*speak about it*". This indication of becoming comfortable within the therapeutic relationship was also demonstrated for those who were seeing clients who had previously been in a different therapeutic relationship. This was most pronounced in participants who had seen clients who had been rejected by other therapists:

[29] (…) represents when statements did not follow directly one after another.

P3 Fiona

"He had been to see 5 different therapists before I saw him. And for one reason and another, it wasn't that they all didn't want to work with him. Generally speaking the message he was receiving is that, 'what you have done is so disgusting. I don't do that type of work', or, 'I don't work with sex offenders" (…) I remember the first session I had with him. He said, "I suppose you are going to tell me that you are not going to work with me", and I said, "no, I am not going to tell you that actually".

Unlike Sophia, Ben and Jennifer, the client seen by Fiona appears to have developed nonchalance to disclosing after past experiences of rejection. While therapists declining to work with clients due to the work falling outside of their competency is not necessarily a weakness in therapeutic work, it is interesting to note the struggle Fiona's client had in attempting to find a therapist to "work" with him. Unlike the experience of Fiona's client, the organisational structure that Sophia works for allows for a more inclusive nature to therapy:

P1 Sophia

"We can work with individuals who have not offended, and just say that they want some help managing thoughts and feelings. If they were being investigated by the police but denied any offences we could still work with them"

Sophia's account details a fundamental difference amongst therapeutic services across the UK, between statutory and non-statutory organisations. It appears that Sophia's construction of who would be welcome in therapy differs to Fiona's client, potentially due to encountering different organisational structures; Sophia's work is based within a non-statutory organisation. While it would be speculative to determine why Fiona's client was turned away from therapeutic services, it is interesting to note Annette's experience of working in statutory and non-statutory organisations.

P5 Annette

"What they might say to me for instance, and we might talk about it – they definitely wouldn't say twice to anyone in a statutory organisation"

The introduction of statutory regulations on reporting incidents (or potential incidents) of CSA brings an added challenge to the already complex field of negotiating disclosure within therapy. Annette's account details having therapy within statutory organisation reduces the likelihood that the client will

disclose. Similarly, Sophia also constructs disclosure as a minefield in which the client needs protecting:

> P1: Sophia
> "In fact it is probably true to say that we would dissuade them from giving identifying information"

Sophia's account adds to the construction of trust within the negotiation of disclosure, with therapists shielding their clients from harmful consequences. Through dissuading the client from providing identifying information, Sophia is able to overcome some client concerns, increasing the likelihood of the client disclosing and remaining within the therapeutic relationship.

5.4.1 Overview of category one: 'Stepping out from the shadows'

Category one represents the negotiation of client's disclosing their attraction to children based upon interrelated processes, as seen within the subcategories (Figure 5.2, p.100). During the process each participant's view was unique, however, there were certain common factors that influenced the client's negotiation of disclosure. These factors include past therapeutic experiences, interaction with the therapist, acceptance from the therapist, and knowledge of statutory regulations.

The participants' accounts, illustrated in this category reflect some of the pre-existing ideas within the literature on SO and potential offenders. Each of the participants acknowledged the importance of building a trusting therapeutic relationship where clients feel able to disclose their attraction to children. Research conducted with SO has highlighted the importance of both the therapeutic relationship and trust if clients are to engage in an honest discourse (Martin, Garske & Davis, 2000; Mitchell & Galupo, 2016). Delays in disclosing, and non-disclosing, has also been attributed to therapist's lack of understanding as to what the definition of paedophilia/hebephilia is (McCartan, 2004; 2010), and a lack of knowledge and support for the therapeutic treatment offered to potential offenders (Jahnke, Philipp & Hoyer, 2015; Kramer, 2011; Stiels-Glenn, 2010). Furthermore, research from European countries has also highlighted that statutory regulations, which mandate therapists to report clients who disclose being sexually attracted to children, *does* impede a client's decision to engage honestly in therapeutic encounters (Fedoroff *et al.,* 2001; Schaefer *et al.*, 2010). Thus, disclosure is a multifaceted process of negotiation.

5.5 Category two: 'Driving them underground'

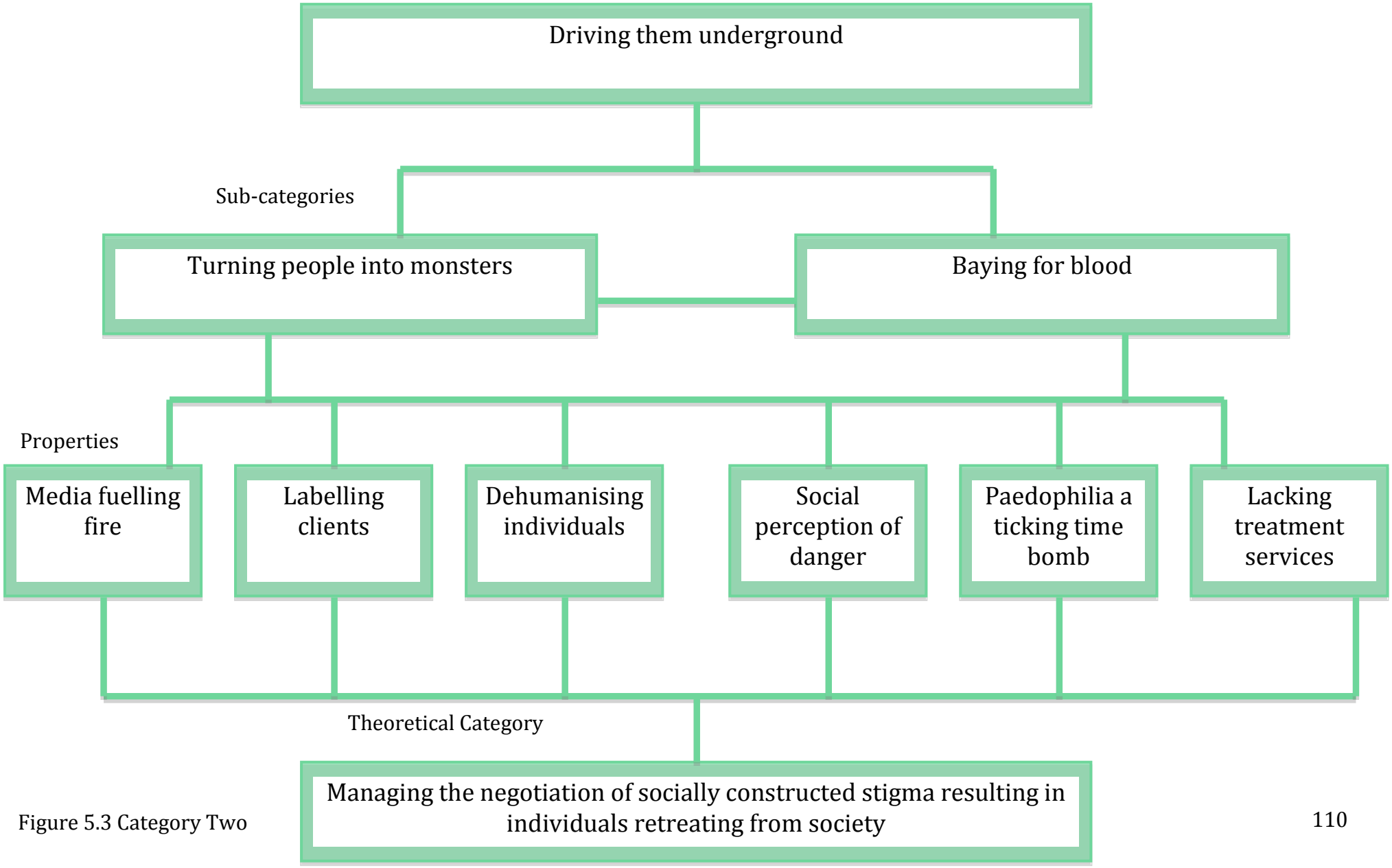


Figure 5.3 Category Two

Category two (Figure 5.3) accounts for participants' construction of meanings behind society's view of paedophilia/hebephilia. The use of "them" within the title of this category was chosen to demonstrate the "otherness" which is often found within discourses featuring this population. When asking participant's about their experiences of working with this population and what could help/hinder the client's ability to abstain from acting on their attraction, societal reactions and encountering stigma dominated the narratives.

The first three participants all explored their understanding of how this population are perceived. Sophia acknowledged how psychological professionals have constructed an understanding of classification where individual's who are attracted to children, but have never acted on their attraction, are classified alongside SO:

P1: Sophia

> "Those I suppose who are not yet convicted, and
> we don't in our heart of hearts know whether they
> are the same kind of people, but from arguments
> sake we kind of take the assumption that they are"

This extract highlights the construction of sex offending not being the determinant within classifying an individual; rather it is the presence of a sexual attraction towards children that determines how psychological professionals will view individuals. While I did not question what this construction of

understanding meant to Sophia, in subsequent interviews I began to explore the socially constructed view of this population. Ben, Fiona and Jennifer explored how society has constructed an accepted view that this population is dangerous, and the impact this construction has on individuals perceived to belong to this population:

> P2: Ben
> "I think that the stigma or turning people into monsters or inhuman is incredibly unhelpful"

> P3: Fiona
> "We view paedophiles like people view those Staffordshire Bull Terriers – they are killers, they are dangerous (…) if you feel like the dregs of society, then there does come a time when you start acting like it"

> P6: Jennifer
> "It is shameful and they feel bad, they feel like monsters for thinking it. They feel like the stereotype of the monster paedophile"

The extracts above all account for a different stance towards 'turning people into monsters'. Ben starts by exploring the practical side of stigma upon this client group, classing such dehumanising perceptions as "*unhelpful*". This

extract starts the discourse on the difficulties facing both client and clinician due to the stigma held towards paedophiles/hebephiles. The extract by Fiona takes this stance one step further, directly exploring the stigmatised perception held towards these clients. Her extract depicts this client group as "*killers*" and "*the dregs of society*". However, unlike Ben, Fiona accounts for a course of motion initiated due to stigma; stigma lights the fuse leading to individual's acting like the monsters they are perceived to be. While accounting for a different take on the role of stigma, both Ben and Fiona's extracts highlight the negative therapeutic appraisal given to the social construction that paedophiles/hebephiles are inherently dangerous.

Jennifer furthers this discourse, however she does so in a manner dissimilar to Ben and Fiona. Jennifer explores the view of 'turning people into monsters' through her client's own self-appraisal. Jennifer explores how her clients view *themselves* as monsters due to their thoughts. While she finishes this extract by stating that "*they feel like the stereotype of the monster paedophile"*, it is interesting that Jennifer's construction of 'turning people into monsters' starts within the client, rather than within society. I consider this dissimilarity between the participants important, the differences highlight that both societal *and* individual influences impact the construction of paedophiles/hebephiles as dangerous. Both social and individual influences are present within the construction of an individual being transformed from human to monster.

The combination of this client group being both dangerous and "*the same kind of people"* as convicted SO resulted in a hard-hitting construction of

inevitability. Fiona (in her extract below) furthers Sophia's constructed view of paedophiles/hebephiles inevitably transforming into CSO:

> P3: Fiona
>
> "He is just a prisoner waiting to happen"

Despite her initial account, Sophia does go on to query the constructed inevitability surrounding paedophilia:

> P1: Sophia
>
> "It all comes back to the social stigma, how much of that people internalise almost like a ticking time bomb. Why should paedophilia be a ticking time bomb?"

Querying why paedophilia should be seen as a "*ticking time bomb*", adds weight to Fiona's statement that "*if you feel like the dregs of society, then there does come a time when you start acting like it*". The current social construction adds inevitability towards an individual becoming a SO. Their attraction is about to explode into action. The extracts demonstrate how social constructions and narratives shape the options available to clients, assuming that the client will become a SO and therefore should be treated like one.

This assumption of inevitability could unintentionally promote the clients' need to hide away from society, inadvertently 'driving them underground'. Annette's account supports this arising theorisation:

> P5: Annette
>
> "There is nothing in place really. Where people can safely go before they are arrested"

Annette's account details the lack of therapeutic services for potential offenders, detailing how there is currently, in the UK, nowhere for individuals to seek confidential support without paying a fee. This adds weight to the category "driving them underground"; a lack of treatment provisions is leading some individuals to hide their attraction to children as there is not a suitable outlet for their concerns.

Furthermore, Sophia, Oliver and Annette describe how the current social construction surrounding paedophilia/hebephilia results in many individuals attempting to hide from society, fearing for their safety. In their accounts they detail the client's perspective, describing that clients are aware of a need to hide their attraction:

P1: Sophia

"Most will also be terrified of the legal consequences, the social stigma, the kind of loss of face with loved ones, letting people down (…) there is a lot of strong social context"

P5: Annette

"They are social outcasts basically (…) I think most are too afraid to say what is going on for them, so they retreat from the social circles they were in because it is easier"

P4: Oliver

"They have probably learnt to keep that fairly quiet, you know you will get beat up if you are a 'nonce' "

These extracts demonstrate the power of the social construction that paedophiles/hebephiles are a danger to society. All the accounts shared the perspective that the current social attitude towards these individuals is resulting in a greater number of people attempting to hide their attraction, either through silencing or retreating from society. Many of the participants' detailed their experiences of the media influencing constructions of paedophilia/hebephilia, fuelling the social construction of damning outcomes:

P1: Sophia

"The shame is, and the stigma, as a practitioner you can't argue with that. You can't sit there and say that's not how it is (…) even BBC readers will use 'paedophile' as the offence (…) just because you are heterosexual doesn't mean you are destined to be a rapist"

P4: Oliver

"This is an ousting and a crusade against any potential sort of sex offender, so you know; they are not immune to that. And I think the media is very influential towards that, I think it is very misdirected in many ways because most sex offenders offend against members of their family, it isn't this stranger out there and the Jimmy Saville types who you keep an eye out for – the dirty old men around the parks. Sometimes it is that, but I think there is lots of these misinformed stories that influence us unfortunately"

Oliver's account details the difference between the socially constructed views of the danger a paedophile/hebephile poses, in contrast to the reality he has experienced. The perceived misinforming by media instils a picture of

individuals needing to hide away from society's glare to avoid being dehumanised.

5.5.1 Overview of category 2: Driving them underground

The participants' accounts paint a similar picture of the constructed stigma paedophiles/hebephiles face on a day-to-day basis. The different subcategories 'turning people into monsters' and 'baying for blood', share properties that incorporate views held by all participants about the impact of stigmatising views on paedophilia/hebephilia.

Research cited within chapter two[30] suggests that societal attitudes towards paedophilia/hebephilia play a role in determining whether individuals feel comfortable to attend therapy (Jahnke, Philipp & Hoyer, 2015; Kramer, 2011; Neutze *et al.*, 2012). Although to some extent the findings from this research demonstrate some inconsistencies (as some attended private therapy), all participants acknowledged that social stigma is likely to drive some clients underground and away from sources of help.

While the role of the media was not a main focus within the present research, the participants' accounts documented the damage media representations can have, fuelling a social hatred for this population. These findings indirectly offer support for the research documented within chapter 2. Whilst the participants' accounts suggest that negative/misinformed media

[30] Please refer to pages 41-43 within Chapter II

portrayals push clients into hiding, previous research has shown that positive media campaigns offering this population therapeutic support, has increased the number of individuals wishing to engage in therapeutic support (Beier *et al.,* 2009a; Van Horn *et al.,* 2015). From the findings, it is argued that both the present research and previous research studies have found similar findings while exploring opposite sides of the same coin.

5.6 Category three: 'Victims of bureaucracy'

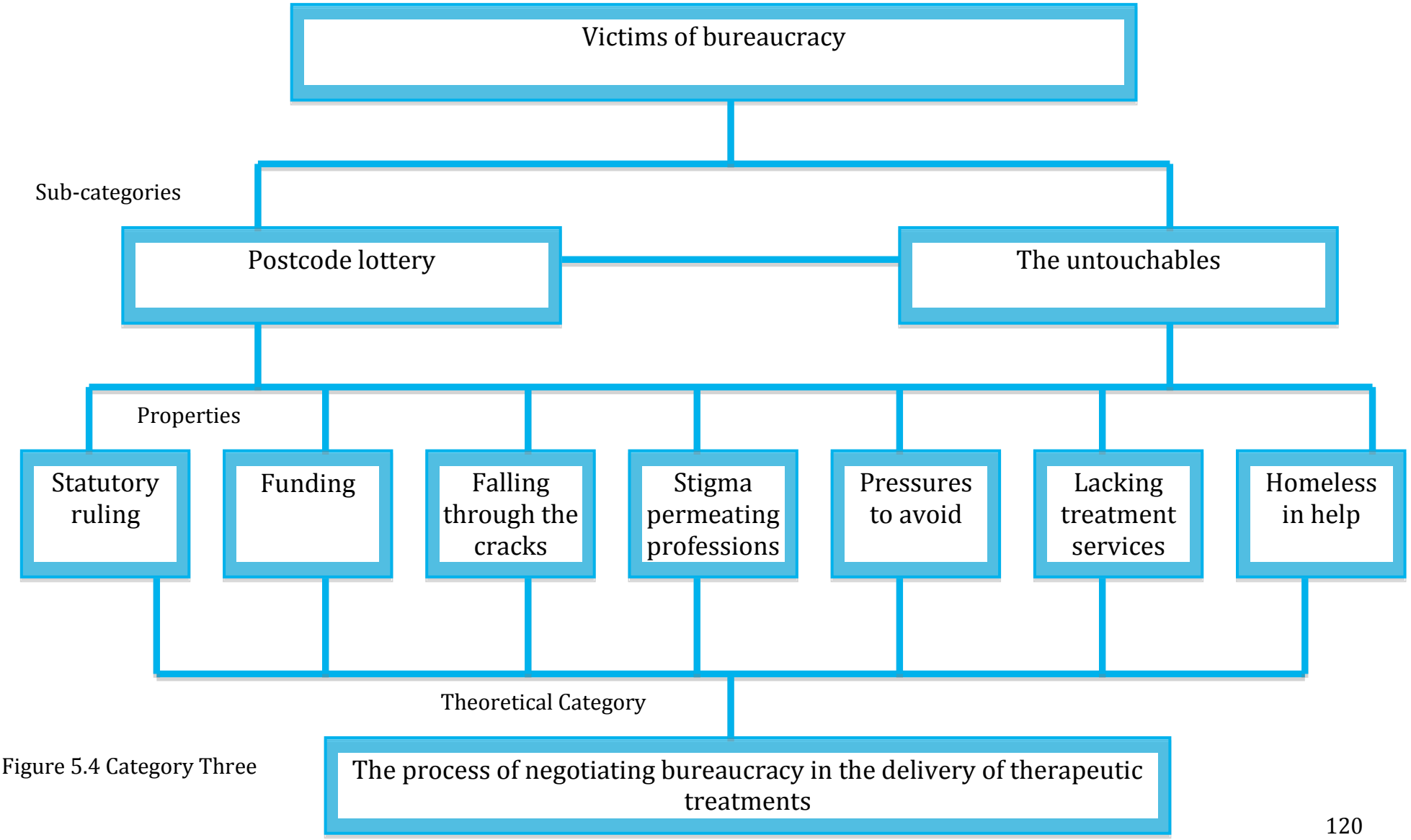


Figure 5.4 Category Three

Category three (figure 5.4) accounts for the navigation of organisational policies during engaging in therapeutic treatment. It incorporates the struggles of negotiating statutory regulations, funding cuts, the 'postcode lottery' of such services, as well as stigma amongst professionals towards paedophiles/hebephiles. Category three illustrates the consequences of these processes, with participants' facing pressure from organisations to follow safeguarding procedures.

Some participants spoke directly about the change in services over the course of their time working at organisations. Most notably the participants' detailed their experience in the demise of treatment options offered to paedophiles/hebephiles:

> P1: Sophia
> "When I first started working here we had more money, back in 2006, a few years around there, practitioners like myself would routinely be on the helpline (…) these days it usually is just the one or two calls with a view to kind of sign posting (…). We are having to charge for our services these days, and we are an expensive organisation, you know, we aren't the NHS and I think that really does, and I've noticed, skew the demographic of who we get"

P2: Ben

"Working in that agency where funding suddenly gets cut or people start off saying that they understand a person needs to come to therapy for two or three years about after six months says we are not doing that anymore"

P5: Annette

"I suppose he had been getting that treatment free and suddenly he was going to be asked to pay something"

Each of the extracts above detail the impact funding cuts have had upon clients. Sophia acknowledges in her account private organisations are able to offer treatment outside the statutory regulations but this comes at a price, reducing the accessibility for a subset of the population. Ben and Annette also highlight the difficulty of managing client expectations when the parameters of treatment could alter at short notice. The participants' accounts allude to powerlessness amongst clients, facing a growing number of hurdles in their attempt to engage with treatment.

The accounts present a similar picture of funding challenges. One aspect unifying the accounts was the participant's witnessing the clients struggle to access a therapeutic service. The accounts presented an image of clients 'falling through the cracks', and having no where to turn to for help:

P1: Sophia

“Some people fall between the two stalls of forensic services and mental health services. Forensics isn’t going to touch you as you haven’t been prosecuted, very often you aren’t even an offender – you don’t have any previous history. You will have to wait and see what happens. A lot of generic therapists, people attached to the primary care model, would say, ‘that’s not really my thing, you know, I can’t really help you with that’”

P3: Fiona

“It wasn’t that they all didn’t want to work with him, generally speaking the message he was receiving is that, ‘what you have done is so disgusting. I don’t do that type of work’, or, ‘I don’t work with sex offenders”

P5: Annette

“There is nothing in place really, where people can safely go before they are arrested”

P6: Jennifer

"It was a fine line between the organisation saying this isn't the sort of client we can see. (…) There was a lot of pressure on me to move him on"

These extracts demonstrate the 'postcode lottery' that obtaining therapeutic support for paedophilia/hebephilia has become. The accounts detail how there is little-to-no services designed to work with this population. The majority of clients fail to meet the criteria needed to access forensic and/or mental health services and are homeless in regards to receiving therapeutic support. As Sophia puts it, "*forensics isn't going to touch you*". The accounts construct client's failing to belong, mimicking the construction in category two where clients fall outside the remits of being an accepted part of society. Paedophiles/hebephiles being viewed as "untouchable" by organisations and society is further demonstrated within the accounts provided by Fiona and Oliver:

P3: Fiona

"We were absolutely not to work with sex offenders. You were not to work with that at all. That was the message. And it's wrong, it is a wrong message because they are not different to anybody else"

P4: Oliver

"'Do you want the scrutiny? Do you want an investigation? Do you want your reputation, or more likely your job on the line?' (…) He didn't explicitly say this but what he means was – should we be accepting sex offenders? (…) If we don't admit sex offenders then we can't get our fingers burnt really"

The extracts detail the pressure placed upon therapists, and organisations, to distance themselves from paedophiles/hebephiles. The participants' accounts show that stigma towards this population is permeating into professional circles, maintaining the constructed fear of inevitability that the individual will become a SO regardless of help. The participants' experiences reflect the negative reactions they have faced regarding their decision to work with paedophiles/hebephiles.

In conjunction with category one and two, the impact of statutory regulations[31] was presented as disempowering the client. Jennifer details her experience of working with a client, who identified as a hebephile, while working for the NHS. Jennifer's account details the pressure placed upon therapists' working within a statutory framework, attempting to balance client safety alongside social needs:

[31] Please refer to Appendix 19, pg.234, for a definition on statutory regulations.

P6: Jennifer

"I, being in an NHS service, I went through the very obvious safeguarding issues that needed to be asked. (…) We talked about that a lot in terms of safeguarding and constantly having to oscillate between is this man being safe and can I help this man in a therapeutic way without putting safeguarding through the roof every time"

The extract highlights the struggle Jennifer faced in promoting the best interests of her client, while continuing to manage the expectations placed upon her to following safeguarding protocols. Her account demonstrates a requirement for a safeguarding limit that clients fall under in order to maintain their position within the therapeutic relationship. This construction was also demonstrated within Sophia's account, despite working for a non-statutory organisation:

P1: Sophia:

"Obviously we would have a duty to report you if we thought something imminently bad was about to happen"

Alternatively, Annette provided a contrasting perspective. Annette detailed the freedom working for a non-statutory organisation has provided her clients. As detailed in category one, Annette highlights how working from a non-statutory organisation removes the constructed silence of safeguarding:

P5: Annette

"We are not a statutory organisation, are not obliged to report to the police. (…) What they might say to me for instance, and we might talk about it – they definitely wouldn't say twice to anyone in a statutory organisation"

Unlike other participants, Annette introduces the concept of safeguarding and reporting back to the police through an ethical lens rather than a legal one. Her account is in keeping with European perspectives, which mandate that therapists cannot breach confidentiality to report a client for being sexually attracted to children (Beier *et al.,* 2009b; Fedoroff *et al.,* 2001; Schaefer *et al.,* 2010). While arguing from a slightly different perspective, Oliver also implicitly reinforces this point, arguing that therapeutic work should not be confined to social preferences:

P4: Oliver

"We shouldn't let public opinion or local politicians dictate how we work clinically"

Each of the accounts highlight how different organisational policies and procedures impact upon clients, with many not aiding the clients, alluding to the construction of powerlessness.

5.6.1 Overview of category three: Victims of bureaucracy

Each participant acknowledged the strain placed on working therapeutically with clients who identify as paedophiles/hebephiles despite the participants working for a collection of different services, ranging between statutory and non-statutory organisations. Sophia, Ben and Annette acknowledged that the cost of receiving therapy is limiting the number of individuals able to access support that is offered. Jennifer was also mindful of needing to continually weigh the balance of offering therapy to clients and triggering safeguarding procedures within the NHS. The impact of safeguarding, and duty to report information to the police, links into category one, impacting the freedom of the client to disclose and discuss their sexual attraction due to fearing the consequences.

Linking into category two, the presence of stigmatising attitudes within therapeutic services presented in the majority of participants accounts. Based on these accounts, there appears to be a tendency for organisations, and therapists, to distance themselves from potential offenders. These findings led to the construction of the property 'being homeless in help', with individual's finding that they have no where to turn to for support. The 'postcode lottery' of having access to a 'willing' private therapist, or non-statutory organisation, added further structure to category three, highlighting that individuals are often victims.

Several studies have shown that mandatory laws on reporting CSA *does* limit a therapist's wish to engage with this client population, as well as the client's ability to access therapeutic support (Beier *et al.,* 2009b; Fedoroff *et al.,* 2001; Schaefer *et al.,* 2010). In addition, funding cuts and reduced treatment options in geographical regions resulting in clients having to travel long distances for treatment has also been documented (Beier *et al.,* 2009a). These experiences appear to influence how participants' view clients as victims within the current UK legal set-up.

5.7 <u>Category Four: 'Therapy: The glue that holds everything together'</u>

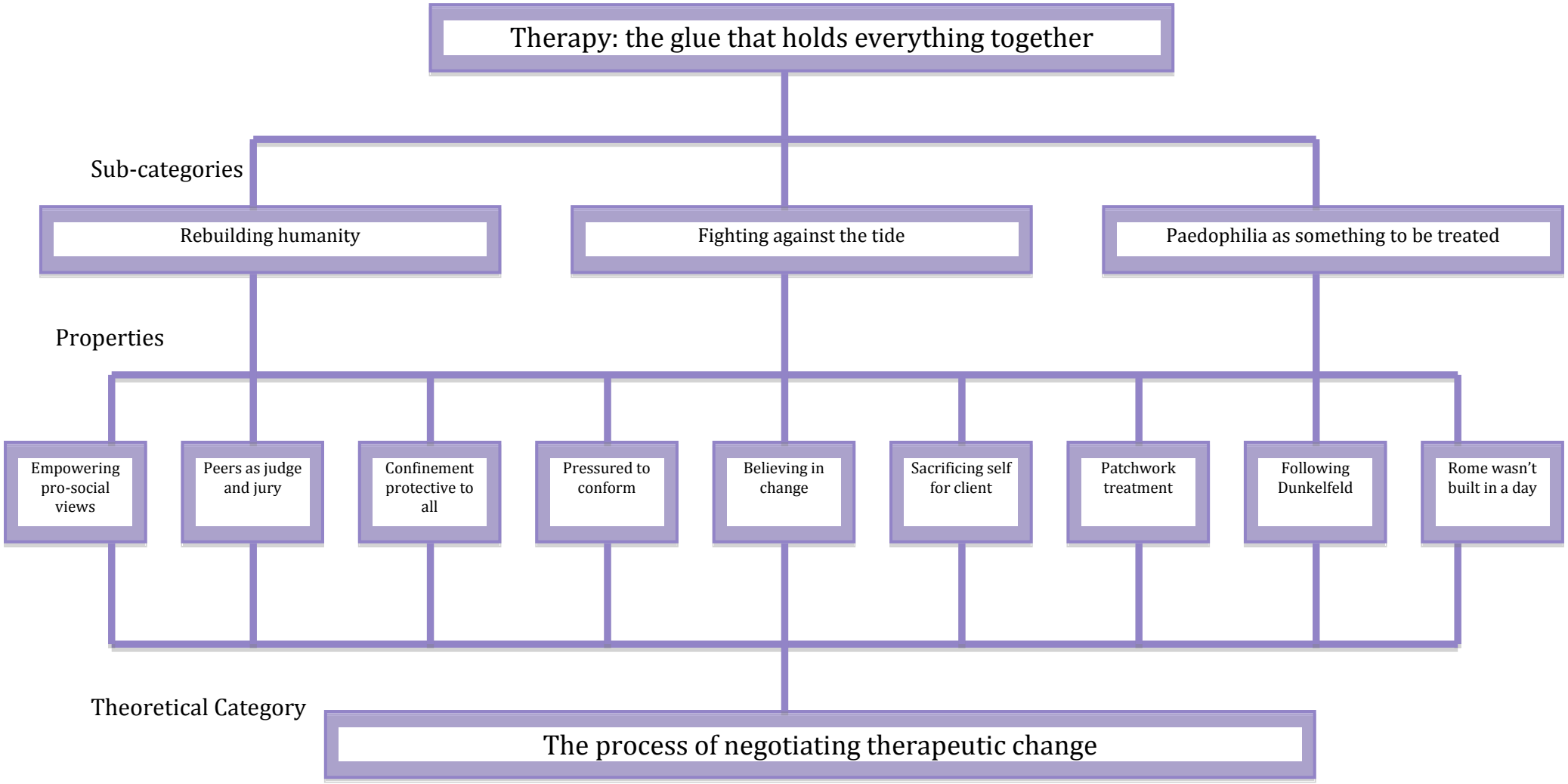


Figure 5.5 Category Four

Category four (figure 5.5) incorporates aspects clients and practitioners face when engaging in therapy after a sexual attraction to children is disclosed. It is underpinned by three sub-categories: 'rebuilding humanity', 'fighting against the tide' and 'paedophilia as something to be treated'. Category four captures the struggle of the participants in overcoming social displeasure at their decision to treat this client population, their perception of what is effective in managing paedophilia/hebephilia as well as perceptions on needing to change the way paedophilia/hebephilia is viewed within psychology. For ease of navigating this category, the findings have been broken down into the respective sub-categories.

5.7.1 Sub-category One: Rebuilding Humanity

Each of the participants acknowledged factors their client's reported to be instrumental in their ability to refrain from acting upon their attraction to children. The majority of these fell under the umbrella term 'rebuilding humanity'. Most notably participants' spoke of the perceived benefit of creating a pro-social support network to surround the client:

P1: Sophia

"Certainly something we all try and work with a person on is rebuilding and strengthening their relationships as protective factors. Pro-social relationships across the offending population is fairly established as protective factors and are no different for the people who contact us"

P2: Ben

"They are able to sit with a group of people who feel to themselves to be approximately the same and where everybody is acknowledging how they are not ok, the not ok part of themselves"

P3: Fiona

"Isolation is your enemy and connection is your friend, so when you are emerged in danger you'll find you are isolated"

These accounts detail the participants' perception that surrounding the client with support is protective. Sophia discusses her view to improve *all* relationships within the client's life. Alternatively, Ben's account details how building a specific group can be protective, providing clients with a platform to express their true identities, emotions and experiences. Fiona takes a different

stance towards connection, focusing on the danger that being isolated could have. Fiona constructs a frame of isolation fuelling dangerous scenarios, alluding to a perception that isolation increases the likelihood of sexual offending. These accounts, although different, highlight a constructed view that increasing an individual's contact with humanity *is* protective. Oliver, who details the benefits of incorporating a therapeutic group into the client's treatment, furthers this construction:

> P4: Oliver
> "'You are not alone' (…) a member of the group will say things that hold them to account. And that is powerful, much more powerful than when a professional would do that"

Oliver supports the construction of rebuilding humanity through the use of groups, while also creating a new construction of peer as judge and jury. Oliver describes the power of interacting with a likeminded peer (paedophile/hebephile) can have for this population. It constructs a view that an opinion from a peer holds greater weight than that of a therapist, having a greater impact upon the client and the choices they make. This construct was also mentioned by Annette who outlined the benefit of an online forum where paedophiles/hebephiles discuss strategies to avoid engaging in CSA. Annette discussed how the forum resembled a therapeutic group:

P5: Annette

"In other words they were therapising themselves"

All the extracts detail the benefits of improving an individual's support network. Thus, improving an individual's connection with society, through a means of connecting them with pro-social individuals, they are better able to live in accordance with societal preferences.

In addition, the participants' discussed their belief that clients' found confinement helpful in their decision to not commit CSA. Participants used 'confinement' in different ways. Oliver detailed how the use of time away from society was seen as protective for the client and the public.

P4: Oliver

"Sometimes a period of confinement or being in a secure hospital is helpful you know. They don't have access to victims, potential victims, obviously no children are allowed in here. So I think a period of time where they are not able to have that sort of access or you know, battle with those urges potentially is very beneficial in the first instinct (…) we don't want to lock people up forever"

Whilst potentially controversial, Oliver argues the protective nature of temporarily removing individuals from society, exploring the client's attraction to children in a safe environment. Jennifer provides an alternative view of how confinement can be protective. Jennifer explores how her client self-imposed confinement to avoid over exposure to sexually arousing stimuli:

> P6: Jennifer
> "He didn't go to swimming pools because that was
> far too much exposure of young boys"

Oliver and Jennifer's accounts, although contrasting, both present the benefit of client's living with confinement: self-imposed or imposed upon them. Fiona expresses another alternative perspective. Nearly all the participants' explored the benefit of regulating emotions and learning self-management in regards to abstaining from CSA. The participants build a social construction of confinement offering the client and community protection via a list of rules an individual needs to live by in order to reconnect with society. These rules, when located within the participants' accounts, are suggested to be forming pro-social relationships, knowing one's limitations.

The final stance on 'rebuilding humanity' was demonstrated through the participants' talk of empowerment, the power of honesty, and instilling a pro-social moral code to abide by. Fiona accounts for the benefit of empowerment through acknowledging that clients are not receptive to therapeutic growth or change unless they have a platform of self-esteem to build from:

P3: Fiona

"'You are not monsters' – because they feel so terrible. They just feel awful. And you can't really work, someone has to have a bit of self-esteem"

Fiona's account attempts to remove dehumanising stigma, as described in category two, due to the limitation it places upon therapeutic work. Jennifer also spoke of needing to reconnect an individual with humanity, however, she did so in a different way. Jennifer accounted for the benefits of an individual choosing to live by a pro-social moral code:

P6: Jennifer

"Spoke about the morals of what he knew was right and wrong. And I think that is related to his sort of religious, even though he wasn't religious, having a moral code based upon his Christian upbringing and Catholic upbringing. So that was important, that there is a certain way that a human should function in the world"

All of the participants' touch on humanity and a need to reform connections. The accounts place therapeutic support as key in relocating an individual amongst society, connecting the rebuilding of humanity to 'therapy: the glue that holds everything together'.

5.7.2 Sub-category two: fighting against the tide

This sub-category illustrates the struggle therapists face when working with paedophiles/hebephiles. The participants' detail two separate constructions of 'fighting against the tide'. Firstly the participants' fight against the public and the pressures of going against the therapeutic norm, and secondly the sacrifices they make for their clients.

In her account Sophia declares her wish to change the socially constructed perception surrounding her clients, and the truth behind the term paedophilia:

> P1: Sophia
> "I wish I could just go out and run down the street
> and say this is what a paedophile is and what a
> paedophile isn't"

Sophia documents her struggle to fight against the tide of social scepticism with regards to the construction of paedophilia. Her account constructs the multifaceted role of therapist, detailing their role of educator alongside their therapeutic role. Similarly, Oliver also details the stigma therapists face:

P4: Oliver

"We have a lack of understanding and a social stigma. (….) You have to fight against the tide. (…) We have to be optimistic. And I am a firm believer that people can change – I wouldn't be here if I didn't believe"

Oliver acknowledges the societal view as problematic, furthering Sophia's suggestion. Oliver's description of fighting against the tide constructs a mounting pressure to conform to society, and society's wish for this population to be "locked up". Oliver defines the need for therapists to believe in the work they are doing, believing they are making a difference to society. Oliver provides a construction of hope to contrast the construction of inevitability discussed within the previous categories. It cements the role of therapist as being multifaceted, building the notion that it is a requirement of psychological professionals to be the turning tide in society.

The second construction of 'fighting against the tide' is demonstrated in the participants' accounts through sacrificing themselves for their clients. One such account is by Annette, who describes the sacrifices she has made to ensure paedophiles/hebephiles are seen:

P5: Annette

"I mean I would always reduce my fee for people that couldn't afford it – I am doing that at the moment for a couple of guys because very often they have lost their jobs through it. (…) I will do extra hours in order to see them quickly because I know how desperate some of these people are"

Annette has sacrificed some of her personal income and personal life to meet the growing demands of her clients. Jennifer, who described needing to fight her organisation in order to maintain seeing her client, mirrored Annette's stance:

P6: Jennifer

"Me fighting to, to carry on seeing him. (…) I perspired so much as I found the whole session, I found the later part, and he was very broken, and I was very worried about him"

Jennifer also displayed a need to go above and beyond in order to offer and maintain a therapeutic relationship with a paedophilic/hebephilic client. While Annette was making sacrifices in terms of finances and time, Jennifer's sacrifice was in terms of her potential position within her organisation as well as an emotional sacrifice. Both of these accounts construct a perception of

therapists needing to go the extra mile for their clients, acknowledging the risk they take professionally and personally when interacting with this population.

5.7.3 Sub-category three: paedophilia as something to be treated

The final sub-category encompasses the participants' perspectives on the pressures to create the "right" treatment for clients, a desire to follow European trends in the treatment offered to paedophiles/hebephiles and their perception on the time they are given to make a difference to a client's life. The therapeutic treatment offered varied from participant-to-participant. The accounts led to a construction of a patchwork treatment, where therapists are left to "fix" the client using the best tools they have:

> P1: Sophia
> "They are the ingredients I think we throw into our work"

> P4: Oliver
> "We try and have a bit of a mish-mash and put it together, but probably CBT is the main approach for us"

Both of these accounts suggest flexibility within therapeutic services on the treatment offered to clients. While on one hand this could construct a pleasant image of tailor-made treatments, it also offers confusion in how best to

work with this population, with the onus falling on the therapist's shoulders to determine the best course of action:

> P2: Ben
> "That is a complicated cocktail of things (…) if people don't get the right kind of cocktail, then that will be unhelpful"

This construction of chaos blurred by views of flexibility and freedom is similar to the findings by previous research conducted into SO, where treatment effectiveness is struggling to be determined (Grady *et al.*, 2012). It appears, from the participants' accounts, that finding the most effective treatment for paedophiles/hebephiles is as complicated as determining the most effective treatment for SO.

When exploring the sub-category of seeing paedophilia/hebephilia as something to be treated, the construction of time showed great importance. A common thread between all participants was the desire for greater time, pushing for the recognition that treatment for sexual attraction is a lengthy process:

P1: Sophia

"We are here for as long as you need us (…) there is no time limit on your contact with us. (…) We can help turn the volume down but we are not going to turn paedophilia into a different sexuality over night (…) potentially going to be a life long issue that they are going to have to manage, for many individuals that isn't going to be achieved in a few sessions of focussed work – absolutely not"

When acknowledging the context of Sophia's work, in a non-statutory organisation where the clients pay per session, there is an apparent flexibility in regards to treatment length. Sophia acknowledges that an individual's sexual attraction is likely to endure for the rest of their adult lives. This is in contrast to the NHS where participants' described a pressure to move clients on. The construction of client's requiring on-going support was also present within Fiona's account:

P3: Fiona

"I see them once a month or every six weeks. Just more as a holding thing"

The constructions of time, and being prepared to offer long term holding presents as a sharp contrast to the common, and preferred, use of CBT within the treatment offered by the participants and the wider psychological community in the treatment of SO. This highlights the confusing contrast between what treatment options are offered to clients, and what the participants' suggest would be most beneficial.

In addition to the confusion amongst determining which therapeutic techniques and treatment lengths would be of benefit to this client group, the final construct of this sub-category arises. Contained within the participants' accounts was a comparison between the UK and German approaches to working with paedophiles/hebephiles. Specifically, the participants' drew attention to PPD:

> P3: Fiona
> "The last training I was at was in Germany (…) they are providing counselling or therapy for sex offenders. It is not mandatory but it is being encouraged and as a result they have lots of people present who necessarily would not have done because it has made it ok"

Fiona details a construction of success within PPD, accessing not only a larger number of clients but also offering an alternative therapeutic message. The construction of success contrasts and challenges the construction of inevitability

from earlier categories, suggesting that therapy *does* promote change amongst clients, initially through attracting them to engage in therapeutic treatments. Annette further comments upon this:

> P5: Annette
> "In Germany, for instance, they regard paedophilia as something to be treated. They are not monsters, they are more regarded as patients".

Annette discusses the social construction in Germany. It builds upon the construction of success and hope from earlier within this category, through changing the social perspective away from paedophiles as monsters and aligning them with other patients, while also determining that change is possible. The accounts provided by the participants in regards to the German social construction offer a vastly different view to that constructed in the UK.

5.7.4 Overview of category four: Therapy: the glue that holds everything together

Throughout their accounts all participants' described the complexities they face in determining treatment length and approaches for each client in line with their own beliefs and the policies set out by their differing organisations. Sophia, Ben and Oliver explored the process of weaving in different elements to form a tailor made treatment for clients. This contrasts with previous

approaches and treatments for SO including GLM[32] (Ward & Brown, 2004) or The Pre-Condition Model[33] (Finkelhor, 1984).

The construction of hope, seen particularly in sub-categories one and three, has similarities with research conducted in PPD. It supports the findings that suggest the offering of hope and directly outreaching therapeutic support to this population increases the number of individual's seeking therapeutic support for their attraction to children (Beier *et al.,* 2009b; Van Horn *et al.,* 2015). The participants' wishful outlook on the work conducted in Germany also highlights the discrepancies between the therapeutic treatments offered to this population within Western cultures, with a particular reference to the vastly different social stances taken within Europe.

In line with the differing stances noted between UK and German treatment options, the construction of 'fighting against the tide' was noted within all of the participants' accounts. This was demonstrated through a need to fight organisational structures and socially constructed hatred directed towards this population. Each of the participants' continued to demonstrate a reflexive stance towards their own personal battles when working with this client group, as well as the wider societal battle they face for offering treatment to an unwanted population.

[32] Please refer to pages 32-34 for the GLM

[33] Please refer to pages 28-30 for The Pre-Condition Model

5.8 Towards a Constructivist GT

The data generated from the interviews resulted in the emergence of four categories presented above and accompanied by supporting statements chosen from extracts from all interviews conducted. Additionally, through continually comparing the different data sets, highlighting similarities and differences amongst participants' experiences, and exploring the links between the four categories and respective sub-categories, theoretical integration was aimed at. This process resulted in the emergence of the final GT (Charmaz, 2006; Bryant & Charmaz, 2007).

5.8.1 Theoretical Integration

The four categories represent the dominating themes that were intertwined throughout each participant's narrative. The theoretical concepts, which grew from each of the categories, provided a different perspective of looking at the themes contained within the data. The emerging GT reflected the interrelations between the categories, sub-categories and properties, forming a theoretical understanding from the connections.

When interlinking and interrelating the four categories, one prevailing theme, "being left in no-man's land", appeared to lend itself to all of the categories, providing the link in joining the categories together, whilst also an *in-vivo code* from Jennifer's account. Category one (stepping out from the shadows) details the client's process of disclosing their sexual attraction to children. The

participants' accounts chartered the client's movements from a place of hidden safety to being under the magnifying glass of safeguarding, and facing potential rejection. From exploring the participants' narratives, it appeared the clients risked being left in no-man's land through opening themselves up to rejection from therapists and society.

Moreover in category two (driving them underground) a vivid image developed from the participants' accounts of their clients being ousted from society, being fired at from all sides, an imagine akin to stumbling around in no-man's land. 'Being left in no-mans land' also interlinked with category three (victims of bureaucracy) where the client's would find being turned away from therapeutic support and struggling due to UK legislation. Finally, 'being left in no-mans land' connected with the final category (therapy: the glue that holds every thing together). However, unlike the links to the other categories where it appeared clients were left in no-mans land, the connection with category four appeared to offer an image of rescue. Category four describes the process of reconnecting individuals with society, building bridges back to humanity, and rescuing the client's from no-mans land.

5.9 Summary

This chapter has shown the results from the research, put forward as a set of key findings arising from the data sets. It has offered a preliminary discussion of the analysed results in relation to the relevant literature. The next chapter continues the discussion of the findings, its relation to existing literature, alongside implications for the field of Counselling Psychology. A critique of the present research is also provided together with reflexive considerations of my role, as researcher, within this study.

Chapter VI: Discussion

6.1 Introduction

The previous chapter displayed the analytic process which was followed throughout this research resulting in the emergence of the final GT: "Being left in no-man's land: Punish first, treat second". This captured the participants' experiences of factors impacting individual's, who are sexually attracted to children, ability to abstain from acting upon their attraction. The four categories were further divided into sub-categories to enhance the understanding of the impacting factors[34]. The subcategories were formed through the combination of different properties which described the different aspects involved within the construction of meaning and understanding, with a final theoretical code emerging from each category linking it to the other three categories.

In category one, 'stepping out from the shadows', the process clients went through in disclosing their sexual attraction to children, resulted in three pathways: enhancing likelihood of disclosure through building trust in the therapist and feeling protected by the therapist; reducing the likelihood of disclosure due to the client being silenced through safeguarding *or* being rejected from therapy due to the nature of their attraction. This involved the incorporation of properties including statutory regulations, therapist perspectives, client's past therapeutic experiences and building trust in relationships. These properties, from the participant's understanding, further influenced whether clients would be able to disclose their attraction towards

[34] Please refer to pg.98 for a diagrammatic version of the final GT.

children. In moving the category into a theoretical direction through the identification of the relationship between the sub-categories and properties, as well as through the linking of it to categories two, three and four, a theoretical code emerged as: "a process of negotiating disclosure in relation to trust building between therapist and client".

Category two, 'driving them underground', was also broken down into two sub-categories[35] reflecting the impact of societal perceptions towards these individuals. Several properties were identified as having an impact upon this process, furthering the participants' understanding that current socially constructed perceptions around paedophilia and hebephilia would reduce the likelihood an individual would attempt to access help for their sexual attraction. This pointed to a parallel process between categories one and two, highlighting the ostracising of these individuals from the therapeutic environment and wider society, based upon the presence of stigmatising viewpoints. By identifying the social processes underpinning category two, a theoretical code emerged which linked it to the other three categories: "managing the negotiation of socially constructed stigma resulting in individuals retreating from society".

Category three, 'victims of bureaucracy', was also broken down into two sub-categories[36]. This aided the understanding of the impact both current UK statutory guidelines, and treatment options, were to have on an individual's ability to abstain from acting on their sexual attraction to children. This resulted

[35] Please refer to pg.98 for a diagrammatic version of the final GT, including sub-categories.

[36] Please refer to pg.98 for a diagrammatic version of the final GT, including sub-categories.

in clients struggling to access therapeutic services, often falling between the cracks due to difficulties in meeting referral criteria. Similarly, clients were also turned away from treatment due to professionals aligning with the stigma as described in category two. Hence, the theoretical code: "the process of negotiating bureaucracy in the delivery of the therapeutic treatments", emerged linking the four categories together.

The final category, 'therapy: the glue that holds everything together', was formed of three sub-categories[37] describing the process of engaging in a therapeutic relationship after a sexual attraction to children has been disclosed. This process led to an understanding that the therapeutic relationship was built on hope, and a belief in change, including the sacrifices made by therapists when undertaking this line of work. The process resulted in an understanding of how therapy elicits perceptions of change, through the incorporation of peers, confinement, empowerment and time. Through exploring this category, a theoretical code emerged: "the process of negotiating therapeutic change", offering an alternative outcome for clients if disclosure, social stigma and bureaucracy could be overcome.

Linking the four categories, and forming the foundation for the final GT was the process: 'Being left in no-mans land: Punish first, treat second'. As described within Chapter V[38] no-mans land encompasses properties from all four categories. This illustrates how the participants are constructing their

[37] Please refer to pg.98 for a diagrammatic version of the final GT, including sub-categories.

[38] Please refer to pages 146-147 in Chapter V.

understanding of what helps and hinders clients based on the interrelations between how they experience disclosure, social stigma, organisational and statutory policies, therapeutic growth and change, and how these are negotiated within the therapeutic environment to allow them to achieve successful outcomes with clients.

This chapter continues by discussing the developed GT in depth, and in light of the literature that was explored during its construction. Once categories were tentatively formed, the literature was consulted to form comparisons with existing conceptualisations (Charmaz, 1990). The four categories are presented below in greater depth, while illustrating the theory's framing within the symbolic interactionism perspective.

6.2 The Findings

6.2.1 'Stepping out of the shadows'

The accounts provided by the participants all illustrated how their clients came to the decision to disclose their sexual attraction to children within the therapeutic room. These decisions were based on a multiplicity of factors such as past therapeutic experiences, trust, statutory regulations, presence of safeguarding and feeling protected by their therapist. These factors extend the findings from existing literature (such as: Amelung *et al.,* 2012; Beier *et al.,* 2009b; Jahnke, Philipp & Hoyer, 2015; Kramer, 2011; Neutze *et al.,* 2012; Osterheider *et al.,* 2011; Schaefer *et al.,* 2010). The present research discovered

disclosure played the role of both a hindering and a helping factor, and the negotiation of disclosure can be divided into three pathways for clients: rejected from therapy due to the presence of statutory regulations and/or stigma, or the acceptance into therapy resulting in enhancing the client's journey to attempt to manage their sexual attraction.

The only element common to all participants, in relation to the wider psychology field, is all of the participants were willing to work with their clients after they had disclosed their attraction, an aspect previously noted as pivotal if therapeutic change would be able to occur for this population (Jahnke, Philipp & Hoyer, 2015). The two pathways negotiated above encompass the remaining three categories forming the final GT ('driving them underground', 'victims of bureaucracy' and 'therapy: the glue that holds everything together'.

6.2.2 'Driving them underground'

Category two represents the participants' accounts of the experiences of shame, stigma and prejudice that their clients face both inside and outside of the therapeutic environment. 'Driving them underground' refers to the process clients endure due to their sexual attraction towards children. Moreover, the accounts showcased the societal perceptions towards these individuals, and how this impacts upon an individual's desire and/or ability to engage with therapeutic services.

Each of the participants had encountered the impact that stigma and prejudiced attitudes had on this client group. 'Baying for blood' encompassed societies desire for punishment. As society casts these individuals as destroyers of innocence, they come to embody social hatred, with society baying for their destruction (Feldman & Crandall, 2007). 'Turning people into monsters', accounts for dehumanising individuals. Through this dehumanising, society is able to distance themselves from this population and deny any similarities. Category four ('therapy: the glue that holds everything together') explores how therapy can be used to rebuild humanity, and reconnect this client group with society (in a manner similar to: Finkelhor, 2009; Osterheider *et al.,* 2011). The present research found that participants perceived reconnecting clients with society as a helpful factor towards maintaining abstinence from sexual attraction to children. The remainder of this section, however, will focus on the impact of stigma on this client group, and the impact it has on their ability to manage their sexual attraction to children.

6.2.2.1 Impact of stigma

'Driving them underground' and 'victims of bureaucracy' encompass the stigma and persecution individuals who are sexually attracted to children face on a daily basis, not only within society but also in therapy. Each of the participants' accounts detailed their clients' experience of facing rejection from therapists or services (similar to the findings by: Feldman & Crandall, 2007; Stiels-Glenn, 2010), or the participants own experience of witnessing colleagues wanting to turn this client group away from services. The accounts led to the view of clients

'being left in no-man's land', having nowhere to turn after being rejected by a profession seen as their last chance of hope. Perhaps it is true to state that as a society we push individuals to retreat through our black and white views of what is, and what is not, acceptable. The present research argues that stigmatising views towards paedophiles/hebephiles hinders an individual's ability to abstain from their sexual attraction to children. While arguably the participants' recounted views are in line with the general social construction of paedophilia, and how paedophiles should be viewed, these perceptions go against the standards of practice outlined by the major psychological bodies.[39]

Moreover, while there is an argument that practitioners should stay within their realms of competence, and rightfully so, there is also an argument that working with presenting issues such as paedophilia/hebephilia should be incorporated into mainstream training programmes to tackle this notion of incompetency. Not only could this increase the number of practitioners who feel able to offer psychological support to this population, but it could also offer a platform for change in attitudes (Jahnke, Philipp & Hoyer, 2015). Through normalising this presentation in training programmes, a notion of 'hope' and 'change is possible' could be fostered amongst trainee clinicians promoting a stronger therapeutic relationship (Martin, Garske & Davis, 2000); within the participants' accounts often such a discourse was adopted by practitioners and clients who found that therapeutic services *could* positively impact individual's wishing to abstain from acting upon their sexual attraction to children. This discourse aligns with the codes of conducts set out by leading psychological

[39] The ethical codes of conduct are discussed on pg.170-173.

bodies, promoting a welcoming attitude to therapy for all. Furthermore, when asked what improvements could be made to the therapeutic services offered to such clients the vast majority of the participants discussed the need for greater training. It was suggested that through the training of professionals, a change in the social tide could be started, slowly steering society away from their current perceptions of paedophilia/hebephilia. Therefore the present research suggests that one factor which could help individual's abstain from their sexual attraction to children, would be further training for psychological professionals on how to work with this population.

While it is acknowledged that tackling stigma amongst psychological professionals and the wider public cannot happen overnight, it appears that efforts to directly target prejudices is proving beneficial for potential offenders. Reflecting back upon the literature collated earlier[40], PPD found that altering the approach taken towards this population (actively encouraging them to attend therapy rather than banishing them from society) led to a significant increase in the number of individuals wishing to access psychological support (Beier *et al.,* 2009a; Van Horn *et al.,* 2015). The advertising campaigns dispelled assumptions that individuals were to blame for their attraction, thus diluting blame while simultaneously placing individuals in control of how they act next (Beier *et al.,* 2009a). While this is only a small stepping-stone towards overturning stigma, it could be said that if cases start to emerge where individuals are able to abstain from their sexual attraction to children, through the support of PPD, the wider public will begin to perceive paedophilia and hebephilia as something that can be

[40] Please refer to pg.37-38 containing the literature sweep in Chapter II.

treated (Van Horn *et al.,* 2015). Despite the fact that this takes time, through the completion of numerous longitudinal studies, it does present as a significant step towards therapeutic services facilitating an individual's ability to manage their sexual attraction to children.

6.2.3 'Victims of bureaucracy'

'Victims of bureaucracy' is placed on the borderline between the two pathways founded from category one ('stepping out from the shadows'). Clients who fall victim to bureaucracy are likely to belong to public services (such as the NHS) and are often rejected from therapy due to the presence of statutory regulations and safeguarding channels. In contrast, clients who attend private therapy, or specific organisations such as LFF or StopSo, are much more likely to escape the impact of statutory regulations (Grayson, 2016) and thus fall into the pathway of being accepted into therapy.

Two discussion points arose from this category: the impact of statutory regulations, and 'homeless in help'. The first, explored the impact that the presence of statutory regulations has on organisations, individual therapists and the clients. The participants detailed the differences between the regulations within the UK and other European countries, this therefore is explored in relation to the literature previously collected within the literature review[41]. The second, 'homeless in help', one of the subcategories forming category three,

[41] Please refer to pg. 34-39 in Chapter II.

explores the participants' accounts of the lack of services open to clients who are sexually attracted to children.

6.2.3.1 Impact of Statutory Regulations

'Stepping out from the shadows' and 'victims of bureaucracy' both touch on the impact UK statutory regulations have on clinicians and clients within therapeutic environments. As noted earlier, currently within the UK there is no law dictating therapists must breach confidentiality and inform the police if a client was to disclose that they were sexually attracted to children but had not acted (Grayson, 2016; Rowland, 2014). However, there is statutory guidance that public services must adhere to (such as the NHS or probation services), and thus are mandated to report any suspicions or concerns regarding actual, or *potential*, cases of CSA[42]. As noted by the participants, this often results in stringent safeguarding procedures where the disclosure, by a client, of a sexual attraction to children must be reported, even if the client is stating they have not, and do not wish to act upon their attraction.

The presence of such statutory guidance has been suggested to lead to a culture of secrecy (Clark-Flory, 2016; Schaefer *et al.,* 2010), with clients and potentially clinicians needing to hide the truth behind disclosure. It was noted in the research by Beier *et al.,* (2009b) that the substantial difference in laws, and statutory guidance, within Germany could be the leading reason behind why German clients feel better able to acknowledge and address their attraction to

[42] Please refer to Appendix 3, pg.210, for The Children Act 2004.

children. It is logical that if you felt under threat of being reported to the police/local authority for your feelings that you would attempt to keep them hidden. This is the suggestion by the participants within the present research. It is therefore suggested that one factor that could aid individuals in their pursuit to manage their sexual attraction towards children is the freedom to discuss it in a safe and controlled environment, without the fear of legal repercussions.

The ethical frameworks put forward by the leading psychological bodies make no explicit attempt to address what a therapist should do if a client were to disclose being sexually attracted to children. Each guideline suggests that the therapist should maintain the boundaries on confidentiality as far as they are legally able to do so. This arguably leaves a large amount of room for individual interpretation amongst therapists and therapeutic services. Therefore, whilst individuals attending private practice, or specialised services, may be able to disclose their attraction without having their confidentiality breached (Grayson, 2016), those who attend a public service are much more likely to be referred through the appropriate safeguarding channels. This gamble on how a disclosure of being sexually attracted to children will be acted upon will undoubtedly have an impact on clients, and their decision on whether to seek help for their attraction. Rightfully, or wrongfully, it will result in certain individuals attempting to hide their attraction rather than entering into the therapeutic system (Kramer, 2011; Neutze *et al.,* 2012).

However, calls by the NSPCC (2014; 2015) and other leading charities to introduce a law where all concerns regarding paedophilia, regardless of whether

an individual has acted, are to be reported (Rowland, 2014), could prove to be a further hindrance in a client's ability to manage their sexual attraction to children. Findings from the present research suggests this could act as a further deterrent for individuals wishing to disclose and seek help for their sexual attraction, pushing them underground, isolating them in their attempt to manage their attraction. In addition to this, it could be suggested that for some therapists it is too risky for them to engage therapeutically with clients who are sexually attracted to children, as they do not wish to be held responsible for the consequences of the clients' potential behaviour. Therefore it could be suggested that introducing a clear ruling like Germany, where therapists are not able to breach confidentiality, would ultimately be more beneficial (Beier *et al.,* 2009b). It would free the client and clinician to solely engage with the therapeutic relationship rather than be embroiled in an ethical and legal debate, which is not applicable unless the client should choose to act upon their sexual attraction.

6.2.3.2 'Homeless in help'

'Victims of bureaucracy' highlighted a fault in the current therapeutic service set-up within the UK. The vast majority of therapeutic services within the UK are not equipped, or set-up, to offer treatment to individuals who are sexually attracted to children but have not acted upon their attraction. As the individuals have not committed an offence they often do not meet the criteria to seek treatment from forensic services which can offer specialised help to these individuals; as noted by Sophia, "*forensics isn't going to touch you*". However, due to the view that paedophilia is a "*ticking time bomb*", many services and private

practitioners decline the option of working with potential offenders, classifying them as 'SO' prior to them having acted upon their attraction.

In addition, the majority of the therapeutic treatment services that are available to individuals who are sexually attracted to children are conducted in the private sector, through private practice and organisations such as the LFF and StopSo. While it could be argued that these services are offering invaluable support, only those in the higher socio-economic brackets have these options available to them. As acknowledged by both Sophia and Annette, the services run by LFF and StopSo are done so at a cost to the client. Therefore, it could be argued that only those with sufficient disposable income would be able to consider attending therapy (Cooper, Purcell & Jackson, 2014; Grayson, 2016). Consequently the therapeutic services equipped to offer support to this client group are only able to access a small sub-set of the population.

The lack of therapeutic treatment services has resulted in the notion of this client group being "homeless in help". Unlike PPD in Germany, the UK does not have a specific service where individuals are able to access help for their sexual attraction free of charge. PPD is the first of its kind in building nationwide support services for potential offenders, crucially recognising that these individuals are not SO and therefore should be provided with different treatment options (Beier *et al.,* 2009a; Marshall, 1997). PPD, unlike its nearest UK counterparts (LFF & StopSo), is able to offer the treatment free of charge. This results in a far greater number of individuals being able to seek treatment for their sexual attraction. Research has shown UK citizens are travelling to

Germany to take part in the programmes PPD is running (Beier *et al.,* 2009b), further highlighting that the UK is not currently offering enough, or the right kind, of support to its citizens' who are sexually attracted to children.

It could, and potentially should, be argued that the current set-up within the UK therapeutic provisions for individuals, who wish to abstain from acting upon their sexual attraction to children, is hindering an individual's ability to manage this. Through a lack of specialised free-to-little charge services, an increasing number of individuals are unable to access the support they desire in their attempt to manage their sexual attraction (Grayson, 2016). Therefore, if Counselling Psychologists and psychological professionals, are to be able to make a difference to this client group, a greater number of treatment options need to be formed. From the participants' accounts, the present research suggests this could be achieved through greater funding for specialist treatment services. Moreover participants suggested increasing the number of services available to clients, removing the post-code lottery effect of clients having to hope that there is a psychological professional within their geographical area that is able, and willing, to work with an individual on their sexual attraction to children.

6.2.4 'Therapy: The glue that holds everything together"

The final category, 'therapy: the glue that holds everything together', was placed within the second pathway stemming from category one ('stepping out of the shadows'): acceptance into a therapeutic service. The notions of 'hope' and

'change is possible' are evident throughout the discourse of each participant. Each participant either believed they could make a difference to the client, or were willing to try and help them manage their sexual attraction to children. While the approach taken by the participants' varied depending upon on their therapeutic approach, organisational structures, or individual factors presented by each client, each of the participants did speak of two similar factors: the rebuilding of humanity, and the impact of time.

6.2.4.1 'Rebuilding humanity'

Encased within 'rebuilding humanity' and 'fighting against the tide' was the participants' desire for their clients, to be treated with care and compassion both inside and outside of the therapeutic environment. This desire forms part of the earlier discussion on stigma, and the increasing need to confront this as a profession (Jahnke, Philipp & Hoyer, 2015).

Fiona's account detailed the damage a lack of compassion can do to individuals who are sexually attracted to children. As Fiona stated, *"if you feel that you are the dregs of society, then there does come a time when you start acting like it"*. The present research argues that holding a negative view towards this population is hindering their ability to manage their sexual attraction (see also: Kramer, 2011; Clark-Flory, 2016). Following on from Fiona's sentiment, if an individual feels that there is no hope or point in changing, as they will always be an outcast from society, it removes any inclination for them to change, pushing them towards acting upon their attraction. While it is for the individual to *want*

to change, it is important to note the influence society can have on whether an individual sees any benefit or point to working towards change (Kramer, 2011; Jahnke, Philipp & Hoyer, 2015).

Despite the negative base this discussion point has arisen from, the present research suggests that treating clients who present as sexually attracted to children with compassion can be beneficial in aiding their ability to manage their attraction. It has been suggested by the participants within the present research, and earlier research (Drapeau, 2005; Lopez-Viets, Walker & Miller, 2002), that displaying compassion can result in the clients' feeling that they are not facing their demons alone. It also adds to a sense of purpose for the clients, they have another reason to not act; and a connection with humanity. Knowing that if they were to act they would lose this connection has been suggested to be beneficial by the participants, adding to a responsibility to change.

Thus, should psychological professionals be using their privileged position in order to lead the change within society's perception of individuals who are sexually attracted to children? By being vocal and offering help to this client group, in a manner similar to that of PPD, the societal perception of this client group being "untreatable" and needing to be "locked up" forever could begin to change (Jahnke, Philipp & Hoyer, 2015). It appears that if society is to allow treatment to be an appealing option for individuals who are sexually attracted to children, aiding them in their ability to manage their attraction, change needs to be fostered by psychological professionals.

6.2.4.2 The impact of time: 'Rome wasn't built in a day'

The second line of discussion is the notion of time, specifically the time offered to clients and clinicians in their pursuit to manage the client's sexual attraction towards children. The majority of the participants aligned themselves as using a CBT/integrative framework and acknowledged that often within services there is a pressure to reduce the number of sessions offered to clients. The type of approach offered to clients, and the benefits that each may hold is outside the realms of the present research. Therefore it is accepted that CBT appears to be the most popular choice amongst clinicians. If, from the data collected by the participants, we take the assumption that the majority of clients who present as being sexually attracted to children *are* receiving CBT it should also be assumed that these clients are receiving short-term therapeutic interventions. CBT, historically, is conducted over a smaller number of sessions, typically offering between 6-20 sessions (Beck, 1964; Beck, 2011). IAPT is one the largest therapeutic services run throughout the UK, and is primarily offering CBT support to their clients. In IAPT services, on average, clients are receiving 4-12 sessions (IAPT, 2011). When compared to the stance taken by psychodynamic, integrative and psychoanalytic practitioners, who typically offer open-ended work if in private practice, or a minimum of 12-15 sessions, CBT offers a substantially reduced period of therapeutic support to clients.

This is not to say CBT is any less effective than its counterparts which are longer in duration, however, it is interesting to note that the majority of the participants are calling for greater treatment lengths when practicing CBT. Does

the clinical presentation of being sexually attracted to children conflict with the intervention design of CBT? It appears from the data collected that there is a valid argument to increase the number of sessions a client receives, and that time is required if an individual is to be successful in managing such a large aspect of their life: their sexual attraction.

If CBT is the most effective therapeutic model for this client group, does it need to be conducted on a more flexible basis? Should individual treatment lengths be determined on a client-to-client basis? The conclusions from the present research suggest that the clinicians appear more confident in their ability to offer the client effective help when they are provided with a greater amount of time to do so. This could be seen within the participants who currently practice privately (Ben and Annette) where they both spoke about seeing their clients for over a year. In contrast, those participants who were tied to organisations often spoke of seeing their clients for one session only, or facing pressures from their organisations to refer the clients on.

If the concept of time is to be of benefit to clients, who are sexually attracted to children, there undoubtedly needs to be further exploration into the impact the number of therapy sessions can have on an individual. These may lead to services such as LFF and StopSo gaining more funding, and being able to offer a greater number of sessions (Grayson, 2016). If nothing else it is hoped that a greater discussion amongst professionals will begin to take place, examining the benefits of different therapeutic options and treatment lengths.

6.2.5 Being left in no-mans land: Punish first, treat second

Through the incorporation of the properties across all four categories the final GT was constructed. Through this construction, individuals (who are sexually attracted to children) are viewed as situated within a context built upon social normalities, stigma, and prejudice, framing the discourses that are available to them. These discourses are further confounded through their interaction with the psychology field, in which they face the risk of rejection, exposure and conflict alongside the premise of hope and change. This construction includes how the individual is constructed by society, as well as how they form constructions of themselves.

The reflexivity shown by the participants throughout their accounts highlight the journey that they have been on with their clients; encountering stigma, shame and prejudice for being willing to work with such clients. A process parallel to the experiences of their clients. Through working with this population they have been able to explore, confront and challenge their own perceptions towards clients who are sexually attracted to children, as well as exploring how they are treated within the psychology field. Consequently, they have constructed their relationships with clients on the premise of hope, believing in the ability to change behaviours and manage the client's sexual attraction. This belief powers the second pathway formed within category one ('stepping out from the shadows'), acceptance into therapy, and is further embodied within the fourth category ('therapy: the glue that holds everything together').

Through exploring the participants' accounts, and forming links between the emerging categories the looming presence of clients "being left in no-mans land" became more pronounced. It appeared whether it was through the delay of police investigations, the fear of public retribution, the clients own desire to hide from their attraction, the denial from services or being classified as an offender despite having not acted upon their sexual attraction, this population were often left 'hanging'. It became increasingly apparent this client group did not belong, neither in society nor in therapy. This formed the first half of the final GT: "being left in no-mans land", with the participants' accounts constructing the presence of therapeutic support as clients' only saviour from no-mans land.

"Punish first, treat second" (the second half of the final GT) was constructed through exploring the options clients, who are sexually attracted to children, had open to them after they had disclosed their attraction. Three main pathways were found embodied within three of the categories: 'driving them underground', 'victims of bureaucracy' and 'therapy: the glue that holds everything together'. The first two of these pathways, and categories, encase the likelihood that an individual is likely to be punished, rejected or dismissed by society for their sexual attraction towards children. The third pathway, although more promising, is only accessible by individuals who are willing to risk being outcast from society and punished for their sexual attraction. When exploring the participants' accounts, punishment or societal retribution, sadly appears the more common outcome for individuals who are wishing to gain help for their sexual attraction to children.

In research conducted into sexual offending as presented in chapter two[43], researchers have noted a pattern of punishing the individual before offering them help (Freeman-Longo & Blanchard, 1998; La Fonde, 2005). Despite calls for changes to this (such as: Freeman-Longo & Blanchard, 1998; Van Horn *et al.,* 2015) little funding has been allocated to offer help to potential offenders (Grayson, 2016). Even with the present research focusing on factors that may help or hinder an individual's ability to manage their sexual attraction to children, the final GT follows on from the pattern established within the field of sex offending, showing a continued pattern of punishing the client before helping.

These dimensions will undoubtedly continue to change as the participants' experiences with this group grow and develop. However, from the present research, the biggest hindrance is the lack of appropriate treatment services available, combined with a crushing stigma and punishing legislation. This pushes clients to attempt to deny and suppress their attraction, potentially increasing the likelihood that they will act upon their sexual attraction. Thus, while attempts are being made to rectify the current pattern of treatment more needs to be done if this client group are to be saved from no-man's land and offered the treatment they desire before acting upon their sexual attraction.

This constructivist GT provides a tentative framework of understanding the factors that help and hinder an individual's ability to manage their sexual attraction to children, via understanding the relationships formed between the

[43] Please refer to pg.22-34 in Chapter II for literature into sexual offending.

emerging categories (Charmaz, 2006). Some of these factors fall external to the clients, such as practitioners complying with the codes of conduct set out by the professional bodies. The interpretative nature of constructivist grounded theories has allowed for the present research to place priority towards the connections that emerged from the data, allowing the findings to be grounded within all of the participants' accounts. While with GT it is acknowledged that multiple truths can exist (Flick, 2011; Guba & Lincoln, 1989; Mills, Bonner & Francis, 2006), and thus different interpretations of the data may exist, the present research proposes one understanding of the data. This understanding is encased within the GT detailed above.

6.2.6 Ethical Dilemma

Each of the categories presented an ethical dilemma, are psychological practitioners in keeping with their ethical codes of conduct? All of the psychological bodies listed within the inclusion criteria of the present study (BACP, BABCP, BPS, COSRT, HCPC, and UKCP) outline their policies on working ethically, each containing a segment on practicing through non-discriminatory means. The HCPC and BPS codes of conduct mandating the practice of non-discriminatory behaviours are listed below[44].

[44] Please see appendices 10-15, pg.224-230, for a full list of BACP, BABCP, BPS, COSRT, HCPC and UKCP ethical guidelines that hold relevance to this discussion point.

HCPC Standards of Conduct (2016, pg. 5)

"*1. Promote and protect the interests of service users and carers:*

Challenge discrimination:

1.5 You must not discriminate against service users, carers or colleagues by allowing your personal views to affect your professional relationships or the care, treatment or other services you provide."

BPS Code of Ethics and Conduct (2009, pg.10)

"Psychologists should:

i) Respect individual, cultural and role differences, including (but not excluding) those involving age, disability, education, ethnicity, gender, language, national origin, race, religion, sexual orientation, material or family status and socio-economic status"

Outlined in the codes of conduct listed above is a clear message – psychological professionals *are not* to discriminate against their clients. However, what appears apparent from the participant's accounts is that this is not the case. Paedophilia and hebephilia, while often considered in terms of addiction, are classified as sexual orientations, with the individual being primarily sexually orientated towards children. Thus it could be argued that clinicians *should not* be discriminating against clients who present as being sexually attracted to children as this would fall under discriminating against a client's sexual orientation. Could it therefore be suggested that practitioners who

deny psychological support and treatment to paedophiles and hebephiles are actually in breach of their codes of conduct?

The codes of conduct also mandate against psychological professionals discriminating against clients, or potential clients, on the basis of their socio-economic status. While it could be argued that therapists are not explicitly discriminating against clients originating from poorer or lower socio-economic backgrounds, by only having treatment options available to those who can afford therapists and therapeutic services are implicitly discriminating against a section of clients. One participant, Annette, directly addressed this stating that she reduces her fees where necessary to incorporate as many potential clients into treatment as possible. This is an active example of the BACP Good Practice Guideline: "*make adjustments to overcome barriers to accessibility, so far as is reasonably possible, for clients of any ability wishing to engage with a service.* (pg.7)" It could be argued that more therapists and therapeutic services should be following Annette's practice, aligning with the guidelines set out by the leading psychological bodies and making therapy inclusive rather than exclusive.

Furthermore, when exploring the participants' desire for this client group to be treated as humans, and for therapists to be able to see beyond the sexual attraction to children to the person within, it is necessary to take a look at the BACP core principles (2016, p.2):

- Beneficence - a commitment to promoting the client's wellbeing.
- Non-maleficence - a commitment to avoiding harm to the client.
- Justice – the fair and impartial treatment of all clients and the provision of adequate services.

Psychological professionals who are not displaying care and compassion to clients who present as sexually attracted to children could be said to *not* be complying with these core principles. Within the participants' accounts it could be said that the therapists who rejected Fiona's client from treatment were in violation of these codes. The dismissal or refusal of treatment to an individual, based on their presenting difficulty, would not be representative of fair and impartial treatment of *all* clients.

Finally, it is put forward by the HCPC that *all* professionals *must not* discriminate. Specifically they state that individuals must not "unfairly treat a person or group of people differently from other people or groups of people" (2016, p.5). This leads to the question of why certain psychological professionals, such as the participants within the present study, feel they are having to *"fight against the tide"* of the common view held amongst their peers that clients who are sexually attracted to children should be treated differently/do not belong within therapeutic services. This perception was also shared by other researchers (such as: Feldman & Crandall, 2007; Jahnke, Imhoff & Hoyer, 2014, Stiels-Glen, 2010) who found this client group were often treated as hostiles within the psychology field.

Throughout Chapters V & VI the damage that holding a stigma towards this client group can have has been demonstrated. Therefore, it also seems of paramount importance to explore how stigma, and potential breeches in ethical guidelines, should be addressed and hopefully reduced. One way of tackling this stigma was suggested throughout the data collected by all participants. Each participant explored the merit of incorporating working with this presenting difficulty into training programmes for clinicians. It is hoped that through engaging with this difficult to think about group of individuals, some of the myths and taboos held by clinicians towards this client group can be brought to light and addressed. Not only would this aid reflexive practice in new trainee clinicians, but also would address issues surrounding feelings of incompetence.

It cannot be expected that psychological practitioners will feel able to engage with individuals expressing paedophilic/hebephilic tendencies unless this client group is incorporated into mainstream training programmes. It should be argued that the only way to overcome the difficulty in thinking about this client group is to directly attend to what makes it difficult, addressing the discomfort, and voicing perceived problems during training. Directly attending to these clients could help to address the fears of working with this client group (for example fear of managing risk effectively and safely, as well as managing personal opinions in the room with a client). Furthermore, this would also open up reflexive discussions around an individual's personal limits to professional practice, opening up a discourse which is of paramount importance if a clinician is to work within their boundaries of competence.

As stated within this chapter[45], there is nothing ethically wrong if a clinician was to decline working with a client due to perceiving the work was outside the remit of their competency. In contrast, this would be upholding of their ethical principles. However, the issue of developing and building competency of working with difficult to think about populations will continue to remain an issue if action is not taken to address this. For example, ensuring each psychology training programme engages fully with difficult to think about groups of people (such as paedophiles/hebephiles). This would help to create a new generation of clinicians who may feel competent, and armed with the right skills, to consider working with such clients should they walk into their practice. Even if this is not the case, and a feeling of competency isn't mustered by addressing this within training programmes, it may encourage practitioners to seek further specialised training within this area.

The present research argues that if stigma held by professionals towards paedophiles/hebephiles is not addressed, there is going to be a continuing lack of clinicians able and willing to offer support. This in turn limits the resources open to clients who are attempting to reach out for support, increasing the likelihood that they will fall through the cracks of the 'postcode lottery' and continue to find themselves 'homeless in help'. Thus the development of more robust and reflexive training programmes, incorporating issues around working with this client group, is necessary if the UK is to follow in the steps of Germany (and specifically PPD) in offering effective help to clients who wish to abstain from acting upon their sexual attraction to children.

[45] Please refer to pg.106 and pg.170-173 for an exploration on working within one's professional competency.

6.3 Reflexivity and limitations within the research process

Charmaz (2006) argued that all constructivist grounded theorists should take a reflexive stance throughout when conducting their research. This includes continued reflection on how meanings are created and understood by the researcher, and their participants (ibid). In chapter one[46] I discussed in detail the assumptions I, and the participants, hold in regards to this population and the development of the present research. Within this section I reflect on how my assumptions were managed throughout the process of data generation and data analysis.

The interview becomes the platform for sharing and generating of knowledge between the participant and the researcher, both of whom also enter their personal identities into the generation of data (Elliott, 2005). At the completion of several of the interviews, the participants would ask me about the research and why my interest fell towards this area. As the collection of data was complete, and my influence on their answers would be minimal, I provided the participants with an honest answer. The participants often agreed, stating that they too had decided to take part in the research as they wished to help this neglected client group. My reasoning behind answering the participants fully at the end of each interview was to ensure that the power dynamics remained equal between the participant and the researcher. I did not wish to hide my own views, after they had declared theirs, and thus adopted an open stance which is encouraged of constructivist grounded theorists (Mills *et al.,* 2006).

[46] Please refer to pg.13-15 in Chapter I.

Furthermore, I offered the participants the chance to see their individual transcripts and an executive summary of the findings once completed. I consider the participants joint creators within the construction of the GT, and therefore considered it would be both appropriate and mutually beneficial for them to see the final result of the research. As the discussion of this research has often focused around abiding by ethical principles[47], I consider that this stance of openness and willingness to share conveys the ethical principle of beneficence (Nagy, Mills, Waters & Birks, 2010).

I consider that the anonymity that was provided to clients created a space promoting the openness and honesty the participants appeared to have within the interviews. The participants spoke with candour, exploring aspects of themselves, their colleagues and their respective organisations in both positive and negative lights. As the research did not focus on their specific services the participants were able to share their experiences without being perceived as attacking the organisations they, or others, work for. I suggest this context helped to shape the construction of the data, gaining insight into areas that may otherwise have been blocked off from inquiry.

The group of participants used within the present research came from a variety of backgrounds (NHS, specific organisations, private practice); therefore, the data reflects different perspectives of working with clients who are sexually attracted to children. Interestingly, those who wished to take part in the research, but were unable to do so due to not meeting the inclusion criteria, had

[47] Please refer to pg. 170-173 in Chapter VI for the ethical guidelines relevant to the present research.

experience of working with SO. It could be that the insight of this group of psychological professionals would have provided further depth to the channels clients who are sexually attracted to children face upon disclosure. However, as they had not worked specifically with clients who had not acted, it is also possible that the data generated within those interviews could have distracted from the aims of the research[48]. Therefore, I consider the exclusion of these potential participants as a strength of the present research, allowing the focus to remain on clients who were sexually attracted to children but had not acted upon their attraction. The data collected, consequently, is of significance as one of the research aims was to contribute to the field of Counselling Psychology in which little had been written about individuals who do not wish to act upon their sexual attraction to children.

It is important to remember that the data collected, and constructed, is being done so on a second-hand basis. Through interviewing participants who were the clinician rather than the client, it is likely that the participants own biases and assumptions might have clouded their ability to recall their clients' experiences. It is also therefore true to say that the factors deemed to help/hinder this client group is also likely to differ to the factors constructed if clients had been the participants within the present research. While this was the initial hope for the present research, an acceptance of ethical restrictions resulted in determining the closest alternative to using clients: their therapists. The present research does not suggest that using professionals rather than clients will generate as much insight into the experience of the client, in fact the

[48] Please refer to pg.53 for the aims and objectives of the present research.

stance taken by the present research is that where possible researchers should choose to use a client based sample (Levenson, Prescott & D'Amara, 2009). The fact that this was not possible is partly due to legal and social views of such clients that has been discussed at length above.

Another consideration regarding the research process is the knowledge base the data was collected from. The influence of existing research (exploring the field of sexual offending and the use of child pornography) on this pool of participants is difficult to ignore. It is undeniable that the participants are likely to have amalgamated their understanding of paedophiles/hebephiles with their understanding of CSO and individuals who watch child pornography. While Merdian *et al.,* (204, 2016) states that caution should be given towards the assumption that these distinct client groups are similar, and thus the treatments, techniques and risk factors are also likely to differ, asking an individual to differentiate between their knowledge bases is a difficult undertaking. With a lack of existing research surrounding the phenomenon of 'potential offenders' (paedophiles/hebephiles who have not acted upon their sexual attraction to children), practitioners are having to rely on combining their knowledge of seen-to-be-similar client groups (child pornography users and CSO) in order to build a platform of resources to boost their confidence and competence of working with this little-known client group.

Moreover, it is also likely that the participants from the present research have worked with CSO and child pornography users as well as 'potential offenders', adding a further complexity in the task of recalling their experiences

of working with 'potential offenders' only. It is therefore likely that when speaking, about what may help or hinder clients in abstaining from their sexual attraction to children, they are also referring to aspects they have encountered as having an impact on other client populations. It could be argued to have been unrealistic to expect participants to be able to distinguish their knowledge and experience of 'potential offenders' specifically without contamination from other experiences they have had. Thus, while I take the participants accounts as a truthful perception of their reality of having worked with 'potential offenders', I am mindful that the factors found within the present research could have been formed due to associations with CSO and child pornography user samples. This adds weight to the call for future research to focus on collecting data first hand, engaging with the clients themselves (Levenson, Prescott & D'Amara, 2009). This would remove the potential overlap between knowledge bases of working with 'potential offenders', CSO and child pornography users.

The final theoretical framework established within the present research makes no claims of portraying a single truth, rather it is one understanding co-constructed between the participants' experiences and my analysis. Moreover, despite theoretical saturation and the quality of the data being seen as significant within constructivist GT (Morse, 2007), the sample size of six used within the present research is small. It is therefore debatable whether the present research achieved saturation, partially due to concept of theoretical saturation being continually debated within the field of GT (Dey, 2007). Despite this, it is acknowledged that a greater participant pool could have led to potentially richer

data being collected, leading to a stronger theoretical framework being constructed.

6.4 Contribution of knowledge and suggestions for future research

6.4.1 Key finding from the research

The use of constructivist GT within the present research, in order to understand the factors that help and hinder an individual's ability to manage their sexual attraction to children, has revealed many issues that are of importance to Counselling Psychologists. This occurred through the offerings of a theoretical framework for understanding the process a client might face after disclosing their sexual attraction to children. The process of forming this theoretical framework has also highlighted insight into areas of interest for future research within this field (Charmaz, 2006).

In recent years, Counselling Psychology has attempted to account for, and integrate, issues of importance such as sexuality into its construction of knowledge in understanding humans (Strawbridge & Woolfe, 2010). Thus, I also considered this as important throughout the undertaking of this research, and consequently have conceptualised the emergence of my GT within the realms of furthering the knowledge in understanding humans. The final GT in accounting for sexuality, culture, social influences, organisational structures, and the negotiations between these properties, provides a new theoretical framework to understand an individual's experiencing after disclosing their sexual attraction

to children, and the factors they face which help and hinder their ability to manage their attraction.

I would argue that the most prominent finding arising from the present research is the negative impact UK statutory guidelines has on paedophiles/hebephiles wishing to access treatment for their sexual attraction. Each of the participants highlighted the numerous ways current legislation would dissuade clients from attending psychological services, reduce the likelihood that a client could disclose their attraction without facing serious ramifications, while also creating a fear amongst professionals, and the public, to engage with such a population. The present research highlighted how psychological professionals are aligning with the stigmatised view of this population (similarly to: Jahnke, Philipp & Hoyer, 2015; Stiels-Glenn, 2010), through following statutory reporting guidelines, removing the option of help from this population in the vast majority of services.

This key finding aligns with the research stemming from PPD. For example, Beier *et al.,* (2009b; also: Clark-Flory, 2016; Grayson, 2016; Schaefer *et al.,* 2010) made direct comparisons between German reporting laws and that of the UK. They discussed at length the 'favourable' conditions that German reporting laws provide to this population, without putting the public at risk. It is also discussed how statutory regulations within the UK are hampering psychological professionals abilities to support and treat this population who are desperately seeking help (Beier *et al.,* 2009b; Van Horn *et al.,* 2015). The present research supports the findings from PPD that changing statutory laws to allow

the disclosure of being sexually attracted to children *should* be allowed within therapeutic contexts, without legal consequences, providing the individual has *not* acted upon their attraction. In line with the participants' accounts, and the findings from PPD, this change in reporting guidance *would not* negatively impact the safety of the public; in contrast it is thought to improve the safety of the public (especially in regards with children) due to more individuals being able to seek support for their attraction before they find themselves acting upon it (Beier *et al.,* 2009b; Grayson, 2016; Van Horn *et al.,* 2015).

This stance is not just being argued in Germany, the argument is already being formed in the UK from the tireless work LFF, Stop It Now! and StopSo (to name a few) are conducting to offer this population the possibility of change without needing to enter legal system. StopSo have gone as far as to suggest that *if* mandatory reporting is to be introduced in the UK, it "*should not include psychotherapists and counsellors in private practice"* and that *"the public is made aware that therapists in private practice are* not *included in mandatory reporting"* (Grayson, 2016 p.1). However, in order to have the success that PPD is finding, services within the UK need to be able to offer the same scope, and safety, of psychological services and treatment. Current UK legislation, and a lack of funding, makes this an incredibly difficult ask of the specialist services listed above (ibid). Utilising freedom of speech, in contrast to mandatory reporting laws, has created an environment where change and management can begin to take place. Furthermore, research stemming from Australia has shown that mandatory reporting laws have failed to reduce CSA (Hansen & Ainsworth, 2013;

Melton, 2005), fuelling the argument 'they doing more harm than good' (Fedoroff *et al.,* 2001; Schaefer *et al.,* 2010).

The present research thus conflicts with the stance taken by the NSPCC (2014; 2015) and others (such as: Rowland, 2014), who suggest that the UK should introduce mandatory reporting laws on *all* cases of CSA, whether actual *or* potential. The findings from the present research suggest that this would dramatically reduce a client's likelihood to engage in treatment, and their ability to be honest with their therapist (Fedoroff *et al.,* 2001; Schaefer *et al.,* 2010). Furthermore the present research suggests that such a law could cause greater harm to the public. Through making it more difficult for such individuals to access psychological support, via mandatory reporting laws, the UK would be leaving this population to attempt to manage their sexual attraction isolated, scared, and unequipped. If paedophiles/hebephiles do not feel safe enough to reach out for help, then they cannot receive support to manage their attraction; additionally, if individuals feel at risk of being reported they are significantly less likely to attempt to access support (Clark-Flory, 2016; Grayson, 2016).

The findings of the present study have important practical implications. UK policy makers have a difficult decision on their hands, to either bow to public pressure and enforce mandatory reporting, or to take the unpopular choice and follow in the steps of Germany who have shown success in treating this population without increasing CSA. The findings from this research argue that this decision does not need to be seen as dangerous, in fact it argues the contrary, making it possible for paedophiles/hebephiles to disclose their sexual

attraction (if they have not acted) is much more likely to reduce CSA (Grayson, 2016) than introducing a mandatory reporting law which will silence an entire population, shunning them from psychological services. The present research hopes to spark debates amongst psychological professionals, UK policy makers, and the general public, to allow for the existence of a different discourse towards paedophiles/hebephiles: change *is* possible, and is facilitated by freedom of speech rather than silencing reporting laws. Accordingly, the findings of the present research may contribute to the discussions surrounding the development of reporting laws, and the development of effective media campaigns targeting this population (ibid) in a manner similar to PPD (Beier *et al.,*2009a; 2009b; Van Horn *et al.,* 2015), while simultaneously promoting the welfare of children.

6.4.2 Future Research

In accordance with the findings presented, it is suggested that if future research were to explore, and hope to alter, the construction of 'Being left in no-mans land: Punish first, treat second', there are numerous areas of interest. Firstly, a further exploration of the UK provisions for therapeutic support offered to individuals who are sexually attracted to children. It would interesting to see what effect increasing the number of services specifically designed for this client group had on the number of individuals coming forward with disclosures of being sexually attracted to children. This would lead to an appealing comparison to the studies carried out within PPD.

Secondly, a further exploration of the pressures therapists face in regards to adhering to legal and statutory guidelines when attempting to work with individuals who are sexually attracted to children would be worthy of note. Each of the participants within the present research spoke about the difficulties either they as therapists, or the organisations they work for, face when attempting to offer therapeutic support to this client group due to external pressures such as the grey-area around when to breach confidentiality (Grayson, 2016). As noted by PPD, the lack of mandatory reporting laws in Germany is thought to significantly benefit this client group (Beier *et al.,* 2009); therefore, exploring this within the context of the UK would form an interesting comparison. Do our legal and statutory laws significantly hinder our clients?

In addition to this, the high prevalence of stigma permeating this client group also warrants further exploration. The current societal perception appears to be crushing the notion that individuals who are sexually attracted to children can change. Tackling this stigma head on, in a manner similar to PPD (such as: Van Horn *et al.,* 2015; Beier *et al.,* 2009b), has proven invaluable in drawing this group into therapeutic services, allowing them to access help while simultaneously removing blame for their sexual attraction. The distribution of a similar media campaign as used by PPD (such as: Beier *et al.,* 2009b; Van Horn *et al.,* 2015) would therefore prove to be of interest to UK Counselling Psychologists. Could this help to draw this client group into therapy? Could it help to alter society's perception that an individual is to blame for their sexual attraction to children?

Most importantly, however, would be for any future research to explore the experiences and perceptions of this population directly. Accessing individuals who are sexually attracted to children, and using this as the population pool for the research. Through collecting their experiences and perceptions the field of Counselling Psychology is likely to gain greater insight into the struggles and triumphs this client group experiences, while also being able to compare whether the opinions, perceptions and experiences of professionals align with that of the clients that are being seen.

One of the primary theoretical approaches developed within Counselling, Clinical and Forensic Psychology for the field of sexual behaviours is regarding the development and application of SOTP (Friendship, Mann & Beech, 2003, Ward & Gannon, 2005). These approaches have developed specific protocols that are used within the field of counselling and psychotherapy for individuals convicted of a sex offence (Finkelhor, 1984; Friendship, Mann & Beech, 2003, Ward & Gannon, 2005). While thought to be applicable to clients who have not yet offended, research and the participants within the present research have highlighted that we do not know if they are the same "type" of person. This therefore warrants a further exploration into the development of treatment protocols for this client group, exploring which treatments appear to have the best impact towards aiding a person to abstain from ever having acting upon their sexual attraction to children. Whether this would turn out to be the pharmacological approach currently being explored in Sweden (Casciani, 2016), or continuing with the psychotherapeutic work conducted in Germany (such as Beier *et al.,* 2009a; 2009b; Schaefer *et al.,* 2010) and the UK (such as: LFF &

StopSo) remains to be seen. However, until further research is conducted the field of Counselling Psychology will continue to remain in the dark about how best to offer help to this client group (Van Horn *et al.,* 2015).

Although on one hand the literature surrounding individuals who are sexually attracted to children, but have not acted upon their sexual attraction, is scarce on the other hand the research that is available shows great promise in being able to effectively work with this client group to reduce the likelihood that they will go on to act upon their attraction (such as: Beier *et al.,* 2009a; 2009b; Schaefer *et al.,* 2010). This indicated that further research was necessary to understand which aspects of an individual's experience was helping/hindering their ability to manage their sexual attraction, especially within the UK where little-to-no specific research had been conducted. Hence, the contribution this study provides Counselling Psychologists and psychological professionals. Firstly, by distancing from existing theory and emphasis that current literature holds towards SO[49], the aim was to add a new dimension to the perspectives on paedophilia/hebephilia, expanding upon the work started within PPD. Through the ability to access numerous different understandings about paedophilia/hebephilia it is hoped that Counselling Psychologists could be steered away from dominant societal biases (Jahnke, Philipp & Hoyer, 2015). Therefore, this new perspective, providing a theoretical framework for understanding what helps and hinders individuals wishing to abstain from ever acting upon their sexual attraction to children, may prove to be useful in conceptualising the work which will need to occur in the therapeutic

[49] Please refer to pg.22-34 within Chapter II for a literature sweep on research into the field of sexual offending.

relationship (Martin, Garske & Davis, 2000). The final GT reflects a position where the therapist can make a difference in an individual's ability to manage their sexual attraction to children.

For this reason, Counselling Psychologists could perceive this theoretical framework as a way of establishing an understanding into what aspects of the therapeutic experience is helping, and hindering, individuals who are wishing to abstain from acting upon their sexual attraction to children. For instance, establishing a strong therapeutic relationship on the premise that the clients right to confidentiality will not be broken providing they *do not* act upon their sexual attraction while in the therapeutic relationship. In addition, continuing to see the person as human and a valued member of society despite their disclosure of being sexually attracted to children. This, while seemingly a basic requirement of therapy, has been argued to provide the client with a connection to society, and a further reason to not act upon their attraction. The therapist therefore plays a pivotal role in facilitating the client to manoeuvre through the many negotiations they will encounter throughout their therapeutic journey. However, like almost all other theories, this theoretical framework should not be forced onto the client, rather it is to be used as a platform from which the individual circumstances of each client can be built upon.

Finally, and arguably most importantly, this theoretical framework is to be used as a platform from which it is hoped future research will spring from, shining a spotlight on a neglected area within the field of Counselling Psychology. With an ever increasing public demand for there to be a stop to CSA (Jutte,

Bentley, Miller & Jetha, 2014), it is important for Counselling Psychologists to use their privileged positions to explore all options available to them; including the offering of help to those who wish to never act upon the sexual attraction they hold towards children.

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Appendices

Appendix 1: ***Crown Prosecution Service Sentencing Manual: Sexual Offence Act 2003***

Beneath is a full list of offences that an individual can be charged with under the Sexual Offences Act 2003

S1: Rape
S2: Sexual assault by penetration
S3: Sexual assault
S4: Causing sexual activity
S5: Rape of child under 13
S6: Assault of a child under 13 by penetration
S7: Sexual assault of a child under 13
S8: Causing, or inciting a child under 13 to engage in sexual activity
S9 and S13: Sexual activity with a child – youth
S9: Sexual activity with a child
S10 and S13: Causing or inciting a child to engage in sexual activity – youth
S10: Causing or inciting a child to engage in sexual activity
S11 and S13: Engaging in sexual activity in the presence of child - youth
S11: Engaging in sexual activity in presence of child
S12 and S13: Causing child to watch sexual act – youth
S12: Causing child to watch sexual act
S14: Arranging child sex offence
S15: Grooming
S16: Abuse of a position of trust: Sexual activity with a child
S17: Abuse of a position of trust: Causing or inciting a child to engage in Sexual Activity
S18: Abuse of a position of trust: Sexual Activity in the Presence of a child
S19: Abuse of a position of trust: Causing a child to watch a Sex Act
S25: Sexual Activity with a child family member (Adult Defendant Only)
S25: Sexual Activity with a child family member (YOUTH only)
S26: Inciting a child family member to engage in sexual activity (Adult Defendant only)
S26: Inciting a child family member to engage in sexual activity (YOUTH only)
S30: Sexual Activity with a person with a mental disorder impeding choice
S31: Causing or inciting a person, with a mental disorder impeding choice, to engage in sexual activity
S32: Engaging in sexual activity in the presence of a person with a mental disorder impeding choice
S33: Causing a person, with a mental disorder impeding choice, to watch a sexual act
S34: Inducement, threat or deception to procure sexual activity with a person with a mental disorder
S35: Causing a person with a mental disorder to engage in or agree to engage in sexual activity by inducement, threat of deception.
S37: Causing a person with a mental disorder to watch a sexual act by inducement, threat or deception

S38: Care workers: Sexual activity with a person with a mental disorder
S39: Care workers: causing or inciting sexual activity
S40: Care workers: sexual activity in the presence of a person with a mental disorder
S41: Care workers: causing a person with a mental disorder to watch a sexual act
S47: Paying for sexual services of a child
S48: Causing or inciting child prostitution or pornography
S49: Controlling a child prostitute or a child involved in pornography
S50: Arranging or facilitating child prostitution or pornography
S52: Causing or inciting prostitution for gain
S53: Controlling prostitution for gain
S57: Trafficking into the UK for sexual exploitation
S58: Trafficking within the UK for sexual exploitation
S59: Trafficking out of the UK for sexual exploitation
S61: Administering a substance with intent
S62: Committing an offence with intent to commit a sexual offence
S63: Trespass with intent to commit a sexual offence
S64: Sex with an adult relative: penetration
S65: Sex with an adult relative: consenting to penetration
S66: Exposure
S67: Voyeurism
S69: Intercourse with an animal
S70: Sexual penetration of a corpse
S71: Sexual activity in a public lavatory
S91: Offences relating to notification
S113: Breach of SOPO or interim SOPO
S122: Breach of foreign travel order
S128: Breach of RSHO or interim RSHO

Appendix 2: ***Seven Divisions within the SOA 2003***

Each of the following criteria is set out within the Sexual Offences Act 2003 (as reviewed and revised in 2012). The corresponding 'S' identification number is also provided with each offence.

S5: Rape of a child under 13

S6: Assault of a child under 13 by penetration

S7: Sexual assault of a child under 13

S8: Sexual activity with a child

S16: Abuse of position of trust: sexual activity with a child

S25: Sexual activity with a child family member

S46: Paying for sexual services of a child

Appendix 3: ***The Children Act 2004***

Only subsections of the Children Act 2004 are contained within this appendix. These are the sections that embody the guidance provided to statutory organisations within England.

Part 2: Children's services in England

11. Arrangements to safeguard and promote welfare
(1) This section applies to each of the following –
a. A local authority in England
b. A district council which is not such an authority
c. A Special Health Authority
d. An NHS trust all of most of whose hospitals, establishments and facilities are situated in England
e. An NHS foundation trust
f. The local policing body and chief officer of police for a police area in England
g. The British Transport Police Authority, so far as exercising functions in relation to England
h. The National Crime Agency
i. A local probation board for an area in England
j. The Secretary of State in relation to his functions under sections 2 and 3 of the Offender Management Act 2007
k. A youth offending team for an area in England
l. The governor of a prison or secure training centre in England

(2) Each person and body to whom this section applies must make arrangements for ensuring that –
a. Their functions are discharged having regard to the need to safeguard and promote the welfare of children; and
b. Any services provided by another person pursuant to arrangements made by the person or body in the discharge of their functions are provided having regard to that need.

13. Establishment of Local Safeguarding Children Boards
(1) Each local authority in England must establish a LSCB for their area.

(2) A Board established under this section must include such representative or representatives of –

a. The authority by which it is established, and
b. Each Board partner of that authority,

As the Secretary of State may by regulations prescribe.

(3) For the purposes of this section each of the following is a Board partner of a local authority in England-

a. The district council;
b. The chief officer of police for a police area
c. A local probation board for an area
d. The Secretary of State in relation to his functions under sections 2 and 3 of the Offender Management Act 2007, so far as they are exercisable in relation to England;
e. Any provider of probation services
f. A youth offending team
g. The National Health Service Commissioning Board
h. Any clinical commissioning group for an area any part of which falls within the area of the authority.
i. An NHS trust and an NHS foundation trust all or most of whose hospitals, establishments and facilities are situated in the area of authority
j. A person providing services in any part of the area of the authority.
k. The Children and Family Court Advisory and Support Service
l. The governor of any secure training centre in the area of the authority
m. The principal of a secure college in the area of the authority
n. The governor of any person in the area of the authority which ordinarily detains children

14. Functions and procedure of LSCBs
(1) The objective of a LSCB established under section 12 is –

a. To co-ordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area of the authority by which it is established; and
b. To ensure the effectiveness of what is done by each such person or body for those purposes.

Appendix 4: ***Recruitment Email***

Dear

I hope this email finds you well.

I am a Trainee Counselling Psychologist conducting research with the University of Roehampton, and am wondering whether you or your colleagues would be able to take part in the research.

I am looking for Psychologists, Counsellors and Psychotherapists (who are accredited with at least one of the following professional bodies: BPS, BACP, BABCP, COSRT, HCPC or UKCP) who have worked with at least one adult client who has identifies as being sexually attracted to children under the age of 16.

Attached is an information sheet that provides thorough details about the research, which has been approved by the University of Roehampton's Ethics committee.

If you have any questions, or are interested in taking part in the research please do not hesitate to contact me.

Yours sincerely,

Anna Turner
Trainee Counselling Psychologist
University of Roehampton
turnera@roehampton.ac.uk

Appendix 5: ***Participant Information Sheet***

University of Roehampton London

Participant Information Form

What is this research about?

This research will be exploring what could aid in the reduction of sexual offending, by exploring what occurs for individuals before they commit a sexual offence. Specifically, this research will be exploring the experiences of clients who self-identify as being sexually attracted to children under the age of 16. This research is aiming to identify factors that could facilitate a client to abstain from acting upon their self-identified sexual attraction to children. This information is hoped to be collected through interviewing psychological professionals who have experiencing working with this client group.

What will be involved?

Each potential participant will be required to meet certain inclusion criteria. These criteria are:

- To be registered and accredited to at least one of the following professional bodies: BPS, BACP, UKCP, COSRT, HCPC or BABCP.
- To have worked with at least one adult client, over the age of 18, who self-identifies as being sexually attracted to children who are under the age of 16.

All potential participants who meet these criteria, and are wishing to take part in the research will be asked to complete an Initial Participant Questionnaire as well as agreeing to take part in a one-hour interview with the researcher. The Initial Participant Questionnaire will be used to collect basic information about each participant, such as the approach you use when working with clients. This questionnaire will be required to be completed and returned to the researcher prior to the scheduled interview. The interview will explore your experience of working with adult clients who self-identify as being sexually attracted to children. The interview will be comprised of questions exploring the context of how you have worked with this client group, the psychological approach you have taken when working with this client group, as well as exploring what you believe has been effective about the work you conduct with client's who self-identify as being sexually attracted to children. Specifically, you will be asked to explore the factors that you believe aid a client in abstaining from acting upon their sexual attraction.

All interviews will be audio-recorded, allowing for subsequent transcribing to occur. You will be provided with your individual transcript, and presented with the opportunity to read and amend your transcript should you wish to provide clarity to any points discussed within the interview.

What happens to the transcripts of my interview?

Each transcript will be provided with an identification number. This number will be unique for each participant, and will ensure that the transcript cannot be traced back to you by anyone else other than the researcher.

You will be e-mailed a copy of your individual transcript and provided with 30 days in which you can read and make any amendments should you wish. After the 30-day period has passed, no further amendments will be able to be made to the transcript. At this point, your transcript will be analysed and collated with other transcripts to form an overall data set. It is hoped that a group of factors will arise from the data which have been found to be useful to client's attempting to abstain from acting upon their self-identified sexual attraction towards children.

Will I be able to be identified from my interview?
The information that you provide will be treated in confidence by the researcher, and you will remain anonymous throughout the research process. You will be provided with an anonymous identification code that will correspond to your audio interview and transcript, each code can only be linked back to a participant by the researcher. Any identifiable information that may be contained within the transcript will be provided with a pseudonym, further ensuring your anonymity. Your identity will continue to be protected in the publication of any findings and all data will be collected and processed in accordance with the Data Protection Act 1998 and with the University's Data Protection Policy.

Can I withdraw my consent?
You are able to withdraw your consent at any point, without needing to provide a reason. However, it should be noted that the data you have provided up until the time of your withdrawal might be used within a collated form. Should you wish to withdraw your consent prior to taking part in the interview please inform the researcher, after this point should you wish to withdraw your consent you will be required to quote the ID number provided on your individual Debrief Form.

What will happen to the data after the research has been completed?
After all data from the research has been collated and analysed, it will be reported and presented in a thesis format. It is hoped that the final research will also be sent to peer reviewed journals such as the Journal of Sexual Abuse. It will be ensured that all data will remain confidential throughout this process, and your anonymity will continue to be maintained both before and after publication.

Researcher Contact Details:
Anna Turner
Department of Psychology
University of Roehampton
Whitelands College
SW15 4JD
turnera@roehampton.ac.uk

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the researcher, the Director of Studies or the Head of the Psychology Department.

Director of Studies Contact Details:

Dr Janek Dubowski
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J.Dubowski@roehampton.ac.uk
020 8392 3214

Head of Department Contact Details:

Dr Diane Bray
University of Roehampton
Whitelands College
SW15 4JD
D.Bray@roehampton.ac.uk
020 8392 3627

Appendix 6: ***Demographic Questionnaire***

Participant Questionnaire

Please complete this short questionnaire and return to the researcher prior to your scheduled interview. By returning the questionnaire you are agreeing to take part in this research. You are free to withdraw at any point without giving a reason, although it should be noted that any data you provide might still be used in a collated form.

What is your gender? (Please tick as appropriate.)

- Male
- Female
- Transgender

How old are you?

_____

What year did you qualify?

_____

Which professional body are you registered to? (Please tick as appropriate.)

- Health Care Professions Council
- British Psychological Society
- British Association for Counselling & Psychotherapy
- UK Council for Psychotherapy
- British Association for Behavioural & Cognitive Psychotherapies
- College of Sexual and Relationship Therapists

Which model of counselling do you use with your clients? If integrative, do you lean towards a particular modality?

_____

Which model of counselling do you prefer to use with clients who self-identify as having sexually deviant urges toward children?

_____

In what contexts do you currently practice? (For example: NHS, private practice, charitable organisation)

_____

How many clients who self-identify as having sexually deviant urges towards children have you worked with?

Total:_____

Male:_____

Female:_____

What are the fewest number of sessions you have completed with a client who self-identifies as having sexually deviant urges towards children?

_____

What are the greatest number of sessions you have completed with a client who self-identifies as having sexually deviant urges towards children?

_____

Researcher Contact Details:

Anna Turner
Department of Psychology
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Whitelands College
SW15 4JD
turnera@roehampton.ac.uk

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator or the Director of Studies or the Head of the Psychology Department.

Director of Studies Contact Details:
Dr Janek Dubowski
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Head of Department Contact Details:
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Appendix 7: ***Ethical Approval***

The research for this project was submitted for ethics consideration under the reference PSYC 15/ 175 in the Department of Psychology and was approved under the procedures of the University of Roehampton's Ethics Committee on 25.06.15.

Appendix 8: ***Participant Consent Form***

University of Roehampton London

PARTICIPANT CONSENT FORM

***Title of Research Project*: An investigation into therapist's perceptions on what factors facilitate the abstinence from sexually deviant behaviours towards children in clients who self-identify as having sexually deviant urges.**

Brief Description of Research Project, and What Participation Involves:

This research explores what factors could facilitate an individual to abstain from acting upon their self-identified sexual attraction to children. It will explore how you, as psychological professionals, have worked with clients who self-identify as being sexually attracted to children, and how you believe therapeutic work could facilitate abstinence from acting upon their sexual attraction.

This research will involve interviewing 8 psychological professionals, including Counselling Psychologists, Clinical Psychologists, Counsellors and Psychotherapists. Participants will be asked to explore their work with clients who self-identify as being sexually attracted to children. These interviews will occur separately to ensure the anonymity and confidentiality of the participants.

The interview will explore your experience of working with adult clients who self-identify as being sexually attracted to children. The interview will be comprised of questions exploring the context of how you have worked with this client group, the psychological approach you have taken when working with this client group, as well as exploring what you believe has been effective about the work you conduct with client's who self-identify as being sexually attracted to children. Specifically, you will be asked to explore the factors that you believe aid in abstaining from acting upon their sexual attraction.

Each interview should last no longer than 120 minutes, and will be scheduled to occur in either your place of work or within the Department of Psychology at the University of Roehampton. Your interview will be audio-recorded via the use of an encrypted audio-recorder, allowing for the interview to be transcribed upon completion. Each interview will then be analysed to determine if there are any similarities between experiences, and whether there are any common factors that are thought to facilitate within the abstinence of from sexual attraction to children in clients who self-identify as being sexually attracted to children. All data that you provide will be stored

under a unique identification number. This will ensure that the data you provide remains anonymous and cannot be traced back to your signed consent form by anyone other than the lead researcher. Results from this research will be reported in a thesis format, with the hope to publish within relevant journals such as The Journal of Sexual Abuse and the Journal of Sexual Aggression.

Below is a list of statements in regards to this research. Please initial next to each statement if you approve:

I have read and understood the Participant Information Sheet.	
I fully understand what is required of me within this research.	
I am aware of my right to withdraw.	
I am aware of who I can contact should I have any further questions or queries in regards to this research.	
I understand that no information, which could identify specific clients, will be collected.	
I am aware that I will be provided with a copy of my individual transcript.	
I understand that I will remain anonymous throughout the research, an my anonymity will be maintained throughout all future publications of this research.	
I understand that the data I provide will be used within a Doctoral Research Project, and has the potential to be published within peer reviewed journals.	

Consent Statement:
I agree to take part in this research, and am aware that I am free to withdraw at any point without giving a reason, although if I do so I understand that my data might still be used in a collated form. Should you wish to withdraw your consent, you will be required to quote the ID number provided on your individual Debrief Form. I understand that the information I provide will be treated in confidence by the researcher and that my identity will be protected in the publication of any findings, and that data will be collected and processed in accordance with the Data Protection Act 1998 and with the University's Data Protection Policy.

Name …….

Signature ……
Date ……

Contact e-mail address (optional) ……

Researcher Contact Details:
Anna Turner

Department of Psychology
University of Roehampton
Whitelands College
Holybourne Avenue
London
SW15 4JD
turnera@roehampton.ac.uk

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator (or if the researcher is a student you can also contact the Director of Studies). However, if you would like to contact an independent party please contact the Head of Department

Director of Studies Contact Details:
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020 8392 3627

Appendix 9: ***Participant Debrief Form***

Participant Debrief Form

ID Number:

Title of Research: An investigation into therapist's perceptions on what factors facilitate the abstinence from sexually deviant behaviours towards children in clients who self-identify as having sexually deviant urges.

Description of Research:
This research has been designed to explore the factors that facilitate abstinence within clients who self-identify as being sexually attracted to children. The findings of this research will originally be published in a thesis format, with the hope to publish in peer reviewed journals such as the Journal of Sexual Abuse and the Journal of Sexual Aggression.

Having completed the interview, I would be grateful if you could sign to acknowledge the following:

- This interview was conducted in an ethical and professional manner.
- That I will be provided with a copy of my individual transcript by the researcher, and that I will be provided with 30 days to read and amend this transcript.
- That I understand my anonymity will be maintained throughout the analysis for the Doctoral Research Project, and any future publications from this research.
- I am free to withdraw at any point without giving a reason, although if I do so I understand that my data might still be used in a collated form. Should you wish to withdraw your consent, you will be required to quote your unique ID number provided on this Debrief Form.

Signed: _____

Printed Name: _____

Researcher's Signature: _____

Whom to contact for more information:
If any issues have come up for you during the course of this interview that you feel may require further attention please inform the researcher and you will be given additional time to discuss this.

If you have a concern about any aspect of your participation or any other queries please raise this with the researcher. However, you are also able to

contact the researcher's Director of Studies or the Head of the Psychology Department.

Thank you for taking part in this research.

Contact details for researcher:
Anna Turner
Department of Psychology
University of Roehampton
Whitelands College
Holybourne Avenue
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SW15 4JD
turnera@roehampton.ac.uk

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator (or if the researcher is a student you can also contact the Director of Studies). However, if you would like to contact an independent party please contact the Head of Department

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Appendix 10: **BACP Ethical Framework (2016)**

Values (p.2)

3. Our fundamental values include a commitment to:

- Respecting human rights and dignity
- Alleviating symptoms of personal distress and suffering
- Enhancing people's wellbeing and capabilities
- Improving the quality of relationships between people
- Increasing personal resilience and effectiveness
- Facilitating a sense of self that is meaningful to the person(s) concerned within their personal and cultural context
- Appreciating the variety of human experience and culture
- Protecting the safety of clients
- Ensuring the integrity of practitioner-client relationships
- Enhancing the quality of professional knowledge and its application
- Striving for the fair and adequate provision of services

Principles (p.2)

5. Principles direct attention to important ethical responsibilities. Our core principles are:

Being trustworthy: honouring the trust placed in the practitioner.

Autonomy: respect for the client's right to be self-governing.

Beneficence: a commitment to promoting the client's wellbeing.

Non-maleficence: a commitment to avoiding harm to the client.

Justice: the fair and impartial treatment of all clients and the provision of adequate services.

Self-respect: fostering the practitioner's self-knowledge, integrity and care for self.

Good Practice (p.5)

10. When the safeguarding of our clients or others from serious harm takes priority over our commitment to putting our clients' wishes and confidentiality first, we will usually consult with any client affected, if this is legally permitted and ethically desirable. We will endeavour to implement any safeguarding responsibilities in ways that respect a client's known wishes, protect their interests and support them in what follows.

Respect (p. 7)

21. We will respect our clients' privacy and dignity.
22. We will respect our clients as people by providing services that:

a. Endeavour to demonstrate equality, value diversity and ensure inclusivity for all clients.
b. Avoid unfairly discriminating against clients or colleagues.
c. Accept we are all vulnerable to prejudice and recognise the importance of self-inquiry, personal feedback and professional development.
d. Work with issues of identity in open-minded ways that respect the client's autonomy and be sensitive to whether this is viewed as individual or relational autonomy.
e. Make adjustments to overcome barriers to accessibility, so far as is reasonably possible, for clients of any ability wishing to engage with a service.
f. Recognise when our knowledge of key aspects of our client's background identity of lifestyle is inadequate and take steps to inform ourselves from other sources where available and appropriate, rather than expecting the client to teach us.
g. Are open-minded with clients who appear similar to ourselves or possess familiar characteristics so that we do not suppress or neglects what is distinctive in their lives.

Appendix 11: **BPS Code of Ethics and Conduct (2009)**

IV Ethical principles (p.10)

1. *Ethical principle: RESPECT*

Statement of values – Psychologists value the dignity and worth of all persons, with sensitivity to the dynamics of perceived authority or influence over clients, and with particular regard to people's rights including those of privacy and self determination.

1.1 Standard of general respect.
Psychologists should:

i. Respect individual, cultural and role differences, including (but not exclusively) those involving age, disability, education, ethnicity, gender, language, national origin, race, religion, sexual orientation, marital or family status and socio-economic status.
ii. Respect the knowledge, insight, experience and expertise of clients, relevant third parties, and members of the general public.
iii. Avoid practices that are unfair or prejudiced.
iv. Be willing to explain the bases for their ethical decision making.

Appendix 12: **BABCP Standards of Conduct Performance and Ethics (2010)**

The Standards of Conduct, Performance and Ethics in CBT (p.6)

1. *You must act in the best interests of service users*

1.1 You are personally responsible for making sure that you promote and protect the best interests of your service users. You must respect and take account of these factors when providing care or a service, and must not abuse the relationship you have with a service user, sexually, emotionally, financially or in other ways. Some CBT interventions may involve you being with service users in social situations but you must still make a clear distinction between personal and professional relationships. If you are providing treatment on a private basis, you must make it clear to the service user at the outset what your fees are and the terms and conditions for you providing the treatment and the service user paying for it.

1.2 You must not allow your views about a service user's sex, age, colour, race, disability, sexuality, social or economic status, lifestyle, culture, religion or beliefs to affect the way you treat them or the professional advice you give. You must treat service users with respect and dignity. If you are providing care, you must work in partnership with your service users and involve them in their care as appropriate.

Appendix 13: **COSRT Code of Ethics and Practice for General and Accredited Members**

Code of Ethics and Practice for General and Accredited Members (p.2)

2. Ethical Principles of COSRT

The code is underpinned by the following ethical principles.

2.1 *Trustworthiness:* striving for the highest standards of professional competence, integrity and fitness to practise.

2.2 *Respect:* for the dignity, autonomy and right to self-determination for the Client.

2.3 *Beneficence:* promotion of the wellbeing of the Client and acting their best interests.

2.4 *Non-maleficence:* avoiding by the member of exploitation and abuse: that is to do no harm to the Client.

2.5 *Anti-discrimination*: commitment by the Member to work on the basis of equality, transparency and fairness.

3.5. Anti-discriminatory practice

3.5.1 Anti-discriminatory practice should underpin all professional activities. The value and dignity of Clients must be recognised at all times. The member must work in ways that respect the individuality of the Clients and colleagues with regard to issues of difference, such as religion, race, gender, age, beliefs, orientation, sexuality and disability.

3.5.2 Issues of prejudice and stereotyping are universal. Members must be alert to their own biases, prejudices and stereotypes and how these may impact upon the therapeutic relationships.

3.5.3 Attitudes, assumptions and values can be identified by the language used and interventions offered. Members must ensure that interventions offered are culturally acceptable to Clients.

3.5.4 Autonomy and right to self-determination of Clients and of others with whom they may be involved must be protected, subject to the limits of confidentiality and safety.

3.5.5 COSRT as an organisational member of UKCP supports the UKCP statement on the 'reparative' therapy of members of sexual minorities.

Appendix 14: **HCPC Standards of conduct, performance and ethics (2016)**

The Standards (p.5)

1. *Promote and protect the interests of service users and carers.*

Treat service users and carers with respect:

1.1 You must treat service users and carers as individuals, respecting their privacy and dignity.

1.2 You must work in partnership with service users and carers, involving them, where appropriate, in decisions about the care, treatment or other services to be provided.

Challenge Discrimination:

1.5 You must not discriminate against service users, carers or colleagues by allowing your personal views to affect your professional relationships or the care, treatment or other services that you provide.

1.6 You must challenge colleagues if you think that they have discriminated against, or are discriminating against, service users, carers and colleagues.

Appendix 15: **UKCP Ethical Principles and Code of Professional Conduct (2009)**

2. *Diversity and Equality* (p.4)

2.1 The psychotherapist undertakes to actively consider issues of diversity and equalities as these affect all aspects of their work. The psychotherapist accepts no one is immune from the experience of prejudice and acknowledges the need for a continuing process of self-enquiry and professional development.

2.2 The psychotherapist undertakes not to allow prejudice about a client's sex, age, colour, race, disability, sexuality, social, economic or immigration status, lifestyle, religious or cultural beliefs to adversely affect the way they relate to the client.

2.3 The psychotherapist undertakes not to engage in any behaviour that is abusive or detrimental to any client or colleague based on the above factors.

Appendix 16: ***DSM-V and ICD-10 diagnostic criteria for paedophilia***

The DSM-V (APA, 2013) has set out three criterions that are required for the diagnosis of 'pedophilic disorder' (302.2):

A. Over a period of at least six months, recurrent, intense sexually arousing fantasies, sexual-urges, or behaviours involving sexual activity with a prepubescent child or children (generally age 13 years or younger).

B. The individual has acted on these urges, or the sexual urges or fantasies cause marked distress or interpersonal difficulty.

C. The individual is at least age 16 years and at least 5 years older than the child or children in Criterion A.

The DSM-V also sets out three specifications that also need to be combined into the diagnosis:

1. Exclusive type (attracted only to children) or non-exclusive type.
2. Sexually attracted to males/females/both.
3. Limited to incest.

Similarly, the ICD-10 (the diagnostic manual used within the UK; WHO, 1993) sets out five criteria that need to be met in order for an individual to be diagnosed with paedophilia (F65.4). These are as follows:

1. Recurrent intense sexual urges and fantasies involving unusual objects or activities.
2. Acts on the urges or is markedly distressed by them.
3. The preference has been present for at least six months.
4. A persistent or predominant preference for sexual activity with a prepubescent child or children.
5. The person is at least 16 years old and at least five years older than the child or children in criterion 4.

Appendix 17: ***Definition of "CSA"***

There is a general agreement across agencies and governing bodies on the definition of child sex abuse (CSA). However, for the purpose of clarity moving forward the definition used for the present research is: penetrative abuse on a child, or where an abuser makes physical contact with a child (NSPCC, 2013).

Appendix 18: ***Definition of "Operation Yewtree"***

'Operation Yewtree' is the name of a police investigation currently being led by the Metropolitan Police Service. The investigation was initiated in 2012, and was formed to investigate allegations of sexual abuse against high profile personalities. Operation Yewtree is formed of three separate strands of investigation:

- Concerns and allegations made against Jimmy Saville exclusively.
- Allegations made against Jimmy Saville and others.
- Allegations made against other high profile personalities such as Rolf Harris, Max Clifford, Gary Glitter and Dave Lee Travis.

The third strand was integrated into the investigation due to a fresh wave of allegations about other high profile personalities being reported to the police. It is thought the volume of fresh allegations against other high profile personalities emerged as a direct result of the publicity surrounding the investigation into Jimmy Saville.

Appendix 19: ***Definition of 'statutory regulations"***

Currently in the UK there is no specific mandatory regulations for individuals, or organisations, to report any suspicions or concerns about child sex abuse. However, there is clear guidance as set out in the Children Act 2004[50], which notes that for statutory organisations in England there is a duty placed upon agencies to co-operate to safeguard and promote the welfare of children. Often in services, in particular statutory organisation, all suspicions, concerns about or allegations of CSA are to be reported to the local authority. Throughout the chapters that follow, when statutory rules and regulations are referred to, it is this specific guidance given to agencies that they *have a duty* to report anything pertaining to, or potentially pertaining to, CSA.

[50] Please refer to Appendix 3 on pg.209 for an outline of the Children Act 2004.

Appendix 20: **Full Transcript and initial codes from interview with "Oliver"**

	1 2 3 4 5 6	I: As you are aware this research is interested in sexual thoughts, feelings and fantasies people might have towards children, and I'm guessing as you have agreed to take part in this research you have some experience of working with such individuals.
	7	P: Yeah
	8 9 10 11	I: So for me to understand what it is you will be sharing today, I was wondering if you could tell me about the context and experience that you have.
Progressing, working way up Working with both sides of the coin Working with the wider context, seeing beyond the offence Returning to the field Displaying loyalty to the field Sex offending infiltrates all areas	12 13 14 15 16 17 18 19 20 21 22 23 24	P: So, I have worked in forensic settings starting as an assistant psychologist starting in 1999 or something like that. I worked with people who were sex offenders, or child sex offenders at that time. As an assistant psychologist I did individual client work, which maybe wasn't offence related specifically, at that time. Probably after that there wasn't much contact for a few years, and then when I got my doctorate I worked in the JH* centre which was in this trust, in about 2003, and I have been working in forensics ever since. Always there is some sex

Distinguishing CSO from other offenders Distinguishing fantasy from offending, yet classifying as similar. Lumping together. Blurring categorisation. Defining expertise. Blurring the lines between CSO and paedophilic thoughts Differing treatments to the needs of the job/client Needing to determine risk. CSO missing from NHS forensic wards. CSO missing from treatment.	25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44	offenders in teams in which I work, not always child sexual offenders or people with those kind of fantasies. But I have worked with a few individually, I have run at least two or three sexual offender behaviour treatment programmes which have included child sex offenders, or people from that background, plus *lots of allegation type of individuals* or you know those kind of things. So I have done individual therapy, some long term, some shorter term and some groups. I have done a lot of risk assessments, and specific sex offender risk assessments for those individuals. Yeah that is the kind of context, so probably all in all you are talking around 12-13 years of being in these kinds of settings. But you know for example I haven't worked with a child sex offender for a couple of years *just because there haven't been any on my ward.*
	45 46	I: And is there a specific way of working with this client group that you use?
Placing trust in CBT practices. Therapists needing to be flexible Accommodating for complexity	47 48 49 50 51	P: Probably if anything it would be CBT. We have to be fairly integrative because we have people with severe mental health difficulties and this is the rehabilitation part where there are primary difficulties. Therefore we have

Altering thoughts to meet client demands. Exploring the thoughts of the client. Using approaches designed for offenders Hoping for the best, learning by trial and error, a confusing patchwork treatment	52 53 54 55 56 57 58 59 60 61	had to think slightly integratively but we are guided by CBT principles so we could be looking at cognitions related to offending, looking at specific models such as the Finklehor model or Good Lives Model which is thought about more commonly now. So there are various things out there and we try and *have a bit of a mish-mash* and put it together, but probably CBT is the main approach for us.
	62 63 64 65 66 67 68	I: So the main focus of this part of the research, will focus on those who there may be allegations but they haven't been convicted. And I was wondering how that might come up in therapy, is that something they would broach or is it something you are already made aware of?
Offending thoughts never hidden Clients being influenced by hospital setting, needing to escape. Disclosing as a barrier to freedom. Feeling constricted by consequences. Clients acting similarly (more homogenous than thought?) Entering the system through guises.	69 70 71 72 73 74 75 76 77 78	P: I am trying to think whether, I can't think of any examples where it hasn't been known but then had come out in a therapeutic session. Given the setting, *every one wants to get out*, or I think every one wants to get out, so *disclosing that sort of information is only going to stall things for them*. So I think they are fairly aware that they are not really going to disclose that, and for most people it follows a bit of a pattern. So some people will have

Working with offenders is more common. Allegations treated the same as conviction. Disclosing once in trouble.	79 80 81 82 83 84 85 86 87	come in for some kind of sexual offence, or some kind of conviction, so typically we would be working with somebody who has some kind of charge or conviction, or if there are allegations. Sometimes new information does come out, they will say there is also this other thing or something similar but it is not usually new information. I can't think of an example where that has happened.
	88 89 90	I: So normally it has come out during previous treatment? And it would be provided to you on a risk assessment?
Needing pre-warning of the client, learning about the client not from the client Being passed from service to service Not trusting the client, going beyond what clients are willing to say, finding out the dirt. Understanding risk as paramount. Data collection as initial response to treatment.	91 92 93 94 95 96 97 98 99 100 101 102 103 104 105	P: Yeah, so when people are admitted to either here or the JH*, usually the JH*, *we receive a pack* and usually in there is their offence history or their charges, or their conviction. Sometimes there is a risk assessment if they have been somewhere else, sometimes it is their first time at a psychiatric service so you get a bit of information. Especially if they are at the acute end you have to *do a bit more digging* to find out things, you might sort of revisit a lot of the court depositions where they are talking about the offence, you would probably want a proper full on risk assessment initially. So you would asking around and gathering

Having nothing to work with.	106 107 108 109 110	information when they arrive at a secure hospital, something like that. You are trying to get as much as possible but it generally builds up over time. Sometimes you are not given a lot information actually.
	111 112 113 114 115	I: And this is something you would, as an organisation, would directly broach with the client? If it was written on a risk assessment? Is it something you make explicit with them that you are aware of?
No hiding from the truth, leading with honesty with clients. Services needing to improve management of risk. Striving for better. Adjusting to social need. Disclosing prior knowledge of clients, sharing the evidence, setting out action plans/conditions that need to be met. Seeing refusals as denial rather than innocence, clients displaying distortions of thought.	116 117 118 119 120 121 122 123 124 125 126 127 128	P: Yeah I think so. I think we are definitely guided by transparency really in terms of risk. And we have made loads of improvements in terms of how risk is managed here, we have risk groups and so on. And even kind of before that, we would be saying we know what your index offence is, or what your conviction is, and you need to do some work on this in order to move on. So yeah I think we would be pretty upfront about that. They might not want to hear it, *or they might want to deny it or will want to minimise it*, but that is always the starting point.
	129 130 131	I: The focus I guess, what they might find useful, beneficial or protective in order to help them not act upon their thoughts, urges

	132 133	or fantasies. Is there anything you have found in this form of work that is beneficial?
	134 135	P: Erm, what do you mean? Therapeutic approaches?
	136	I: Anything really?
Protecting through confinement, helping through custody. Removing options. Removing access, stopping behaviours through removing choice. Building a fantasy treatment scenario – removing from reality. Removing freedom to act. Battling thoughts without access to behave. Protecting children is fundamental to treatment. Separating potential offenders from potential victims. Segregation as protective to all. Increasing risk throughout treatment. Pushing limits, "testing people out", pushing trust, expecting failure? Own training influences factors deemed helpful. Distinguishing opinion from other professionals. Managing risk through therapy. Needing to understand likelihood of offending. Risk determines all.	137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158	P: Erm well I think on the basic level *sometimes a period of confinement or being in a secure hospital is helpful* you know. They don't have access to victims, potential victims, obviously no children are allowed in here. So I think a period of time where they are not able to have that sort of access or you know, battle with those urges potentially is very beneficial in the first instinct. So I think that is quite practical because you know, many offend against children in their own family. So having that sort of separation is a very useful first step, so then you can begin to build up the risks by take a few more risky things. So giving people leave and *testing people out*, and those kind of things really help and yeah are beneficial. I think therapeutic approach, and I speak as a psychologist, is what we think is a huge part of managing the risk really. So it is about understanding the risk behind their offending, understanding their triggers and

Moving beyond CSO, blurring lines in classification. Seeing paedophilia/hebephilia as an illness. Attitudes like an addiction. An addiction of the mind. Exploring the role fantasy plays. Breaking down the meaning of fantasy life. Extending work from offending to CSO. Moulding into one. Classifying as CSO. Following ideas rather than evidence. A guessing game? Acting on impulse. Being overpowered from within. Fragmenting the steps to acting. The desire to act. "You have to have the intention" – the difference between offenders and non? Facing peers as a greater aide to treatment, facing peers rather than an alien professional. Challenging oneself through others. Funding impacting treatment, removing of speciality and specificity. Reluctant to engage publically. Stigmatising occurring in treatment, bullying by other sex	159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187	things like there is a lot of overlap with other kinds of offending, but it is about understanding their illness, understanding their drug use, understanding their attitudes towards children or with other offenders it is others. Understanding their fantasies and I guess you know, sometimes, I think that Finklehor model, I don't know if you know it very well but it is the steps to sexual offending model, and it applies to child sexual offending. So it is this *idea* that there is various steps you have to do in order to offend. It is actually quite helpful for service users, and use when they say, "it was in the moment, I couldn't help it". And when you break it down, there is these sort of four steps, *you have to have the intention*, you have to overcome internal inhibitors as well as external things, and have motivation – those kinds of things. So actually breaking it down in that way is actually quite helpful. Erm peer support and peer challenge I think is helpful. So you know, in groups we run, we often have mixed groups – adult sex offenders and child sex offenders often in the same group. Mainly because of numbers, we can't get enough numbers to fill up a group. And that has its own advantages because sometimes child sex offenders get quite

offenders, distinguishing as vulnerable, bottom of the pecking line. Alleviating fear of isolating, "you are not alone" building hopes, creating a community. Overwhelming shame from facing stigma. Silencing shame. Needing to break down rationalisations. Peers as judge and jury. Removing the option of denial/avoidance. Having to face the truth. Confronting a mirror image rather than a distorted reflection.	188 189 190 191 192 193 194 195 196 197 198	stigmatised within that sex offending group actually. But on a sort of more general scale, normalising it and saying you know, *"you are not alone"*, because there are these huge amounts of shame and guilt. And you know getting challenged, "I was just doing this", the minimisations that occur – a member of the group will say things that hold them to account. And that is powerful, much more powerful than when a professional would do that. So that is kind of really helpful.
	199 200	I: It makes it more real for them if it is from a peer rather than a professional?
Voice of a professional lacking impact. Preaching tones form an unintentional barrier to change. Alienating clients through wording. Confronting with powerful reality. Using peers to confront distortions. Wanting for clients to experience truth. Professionals will always be on the outside? Using the power of peer, removing social difference as a	201 202 203 204 205 206 207 208 209 210 211 212 213 214	P: Yeah, I think so because they probably all have experienced professionals saying, well you know we don't mean to, but it can sound a bit preachy and drab when we say, "you should take responsibility for this, that and the other. But if you have someone else who has also committed a sexual offence say, "when you walk down the street and found yourself chatting to that child for example, did you not sort of plan that a little bit? Were you not going down that street because you knew you would bump into someone?", you know and just having that, it hits home rather than us saying "no, no, you are just being negative

barrier to reality. Looking beyond what the client can do for themselves. Needing to build community connections, extending the boundaries of treatment, sharing knowledge between professionals as paramount to managing risk. Releasing with boundaries. Removing *ability* to offend rather than tackling *want*.	215 216 217 218 219 220 221 222 223 224 225 226	when you think like that". I think that is a very powerful intervention. Beyond that I think a lot of the work we do is just to build up really good external controls, so some change and some don't. It is trying to have a really supportive community team for when they move on, who are fully aware of their risks and we can sort of prevent access to victims potentially. Through very strict monitoring and involvement with community services that is really helpful as well as it stops them from offending.
	227 228 229	I: So when you say external controls, could you give an example of something that might be put in place?
Using risk to exclude individuals from society. Imposing barriers and rules. Connecting services together. Reporting to agencies as standard. Removing privacy. Breaching anonymity as a strategy to reduce risk to children.	230 231 232 233 234 235 236 237 238 239 240	P: Erm sometimes some geographical areas are restricted so *you are not allowed to* enter a particular borough or a particular postcode. Particularly if there is a specific victim, such as a family member or something like that, so that reduces the risk greatly. It could also be informing the governing bodies like MAPPA and having them in discussions, or the police in *knowing where the individual lives* I think is also really useful. So those kinds of things, making sure it is planned really.

	241 242	I: And can those exclusions be self-exclusions or would they be imposed upon them?
Making decisions for the client. Not risking harm to the public. Making impositions. No escaping imposed boundaries. Facing consequences for their actions. Gifting the clients with their release. Signing up to a discharge programme. A business deal?	243 244 245 246 247 248 249 250 251	P: They are often imposed, yeah. So yeah often you have conditions of discharge where it says you are not allowed to enter that borough, or go within 500m of the family home – something like that. And if you are found to breach that then you can potentially get recalled or put back on, if it a prison sentence, call backed effectively. So yeah often it is built into the *package*.
	252 253 254	I: And how do they find that? Do they find it safer because those restrictions are put in place?
Enforcing actions despite disapproval. Going against the wishes of clients. Justifying constraints placed on clients. Safety in lack of options. Needing a lack of options. Guessing what is useful for clients. Anger inducing constrictions.	255 256 257 258 259 260 261 262 263 264 265 266	P: Erm, I think they often resent it. Particularly if they are – it depends how much insight they have got – some individuals think it is useful for them because you know particularly if they feel they are struggling with urges to offend and they think well I cant get anywhere near my children. They might think that is quite helpful, but there is plenty who would think that that 'you are just being restrictive and there is no need for me to not go there, it is out of order'. So it is a mixed bag really.

	267 268 269	I: And would you say those who are more accepting have a potential to do better in regards to abstaining from their urges?
Insight as the key to change. Learning from factors associated with sex offenders. Applying knowledge to a different client group. Lacking acceptance of impulses as a risk factor for offending. Providing insight is beneficial in therapy. Associating ambivalence with offending. Needing help from others, going beyond the means of the client. Using restrictions to contain concerns. Alleviating fear through boundaries. Learning from past vulnerabilities. Learning from the client.	270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293	P: I think so yeah. I think insight is quite a key thing. I did some training last week on stable and acute risk assessment, I don't know if you know it? It for sex offenders and they have got these particular factors that are very much associated with the risk of them reoffending. And I don't know why I mentioned that, but thinking about their risk factors in terms of those who are more accepting is very much to do with those who see sort of their urges and impulsivities as a big factor and have an insight into that. So yeah I do think they find that useful. There is one guy who I have been working with for example, offended against his children or his stepchildren and he – I think he was quite ambivalent. On the one hand he would say he couldn't help himself and he kind of minimised it a bit, but on the other hand I think there is something quite containing about knowing he couldn't have any access to his children. Given that it has been problematic in the past. So I think on the whole for him, it was actually quite helpful and he found it helpful.

	294 295 296 297 298	I: So I am guessing that if you don't necessarily don't approve of what you are doing, having that restriction could be safety inducing? Knowing you wont go over your own boundary?
Holding the client through constriction.	299	P: It can be very containing, I think yeah.
	300 301	I: And they have discussed the importance of family dynamics in helping them to abstain?
Sex offenders as a minority client group. Stemming from dysfunctional homes. Developing outside the social norm. Shaping through shared experiences. Lacking stability and safety as a childhood risk factor. Fighting on their own. Dysfunctional support worse than no support? Families blurring the lines between social norms. Growing up in a different 'norm'. Dysfunctional family norms causing irreparable damage to individuals. Restricting access to damaging normalities. Removing	302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318	P: Erm, I am just trying to think. It is quite hard. People who are child sex offenders, and I mean there isn't loads in this service, when I think about their families – it has been quite dysfunctional. Often they may have been abused themselves as a child and I often think there is quite a disintegrated sort of family. So, just the ones who come to mind are, they have had very little family access and support. And when there has been access or support it has been quite problematic so there is a guy on one of the wards here who offended against his own daughter, and there is a whole culture in that family of very unclear boundaries and sex between family members, things like that. And the family is actually very destructive for him, when he has contact with

previous family norms. Needing to isolate individuals, stopping the cycle. Lacking evidence for family support as helpful.	319 320 321 322 323 324 325	them it is destructive and it really sets him back and stresses him out. We try and restrict that quite a lot. I can't, no examples come to mind where a family has been really supportive for those with child sexual offences. Adult sex offenders there is a bit more evidence of that.
	326 327 328 329	I: I guess that might be the difference between someone who hasn't acted and is seeking help, in comparison to someone who has crossed that line?
Attempting to work with ideals. Wanting the client to want to change. Telling the client what they want. Taking ownership with the client. Creating a joint responsibility. Educating social sexual norms. Challenging moving forward. Dealing with more than the offending urges. Continually being tested as a therapist. Needing to go above the client. Looking externally rather than internally. Containment as the professional preference. Distinguishing mental health patients from offenders. CSO as developmental, nurture rather than nature.	330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345	P: Yeah, ideally. Yeah I mean you know, ideally for these guys you would say, "lets think about it, *you want to* work on your boundaries and relationships and *we need to* really think about what is appropriate and inappropriate sexual relationships". But often is quite difficult to get beyond that, you have very chronic people especially here in the rehab setting where boundary issues are constantly at play. On the ward they are getting tested out with staff and yeah sometimes they can get it a bit more and can be a little bit more self-contained but often it doesn't quite get there and you have to think about external containment really. That is the ideal, but I think we have got a different kind

Changing behaviour to be left alone. Behaviour holds the key to escaping? Facing limitations within organisations. Needing extensive support, requiring more than can be given. No overcoming the problem. Fruitless aim of help?	346 347 348 349 350 351 352 353 354 355 356 357 358 359 360 361 362	of client group compared to maybe sexual offenders in prison who are maybe more high functioning or feel like they slipped up. But here it is often born out of more chronic behaviours and difficult upbringing. But yeah that would be the ideal and altering those behaviours so they can kind of just get on with it. Yeah recidivism is quite high in terms of child sex offenders, it is something that in a setting it is hard to sort of reduce those rates. You know, with a lot of therapy and a lot of input you can reduce it. There is a lot of research showing that, but not by huge amounts. So it is kind of this group where you think it is always going to be a bit of an issue, particularly if they have got deviant fantasies and things like that.
	363 364	I: And more so if they have added difficulties on the side, such as mental health difficulties?
Facing a multitude of difficulties. Going beyond the scope of specific services. Mental health difficulties adds fuel to an already uncontrollable fire. Living outside of reality, building their own norms. Nature taking over.	365 366 367 368 369 370 371 372	P: Hmm yeah, exactly. We are dealing with a lot of co-morbidity problems. So chronic schizophrenia, or personality disorder, just sorts of complicates the picture a whole lot more. And sometimes the offending is based upon delusional thinking, and sometimes it is based on sort of pure sex offending type attitudes. Sometimes it is to do with their

	373 374	personality, so yeah it does get a bit more complicated, very complicated actually.
	375 376 377 378	I: And have you noticed from working within the different settings that there is a different approach that is required to work with this client group?
Needing to rework treatments. Classifying all as sexual offenders. Generalising the clients. Grouping all together due to structural difficulties. Working with limitations. Lacking a desire to engage. Willingness to accept help not present in all. Asking for commitment from clients. Clients being forced to wait. Dealing with constraints to get help. Services unequipped to offer support. Lacking immediate access to help fuels risk? Lacking suitable definitions, searching for acceptable catagorisations. Going beyond sex offending, needing to explore relationships in a wider context. Building a programme to suit the needs of the presenting	379 380 382 382 383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399	P: Erm, well we have just been reviewing our pathways for sex offenders here actually. What we felt is there is probably a need for, because typically we have had a sex offender treatment programme that is kind of for all sex offenders with a conviction and it has been quite hard to get enough numbers. Even though we are quite a large service the number of people willing to engage in that is actually quite small so you can kind of typically start a group with 8 or 9 people. It is quite a long group, just over a year of weekly sessions, and sometimes it takes a good year to get on the waitlist before you can start the group. So we thought what we probably need is to revisit it. There is probably a sub group that, I don't know how define them, but high-risk sex offenders, where sex offending is their main, they main issue – their main problem if you like. So targeting that with a specific sex offending group. But we have a lot

clients. Dealing with allegations. Classifying the severity of the behaviour to determine treatment. Changing the services offered to clients. Moving to a unified approach.	400 401 402 403 404 405 406 407 408 409 410 411 412 413 414 415 416 417 418 419 420	more patients who have difficulties with relationships more generally, so that might be expressed with, we have got quite a few people where it is alleged that they have raped someone or have committed another sexual offence, or are very sexually inappropriate on the wards with staff – maybe lower level offences such as exposure. Or more general relationship difficulties such as domestic violence problems and I guess what we thought is that there is a need for a group to look at more general relationships and tackle lower level sex offending type behaviours. And I think that is where we are heading actually, and other sexual offending services do something a bit similar. So like a relationships type group, tackling low level plus domestic violence and relationships and then maybe a sort of more hard core group which you might see more of in high secure settings.
	421 422	I: And would that be increased in frequency, or more focussed in content?
Improving ability to engage in societally accepted ways. Educating social norms.	423 424 425 426	P: Erm, I think it would be different content. So I would envisage the relationships to be a bit more general and maybe focussing on social skills type interventions. Maybe

Challenging and reframing attitudes.	427	thinking about attitudes a lot, that is relevant
	428	to both groups. And think about the
	429	generalisable skills, because we do quite a few
	430	different groups where we think there is a lot
Teaching self-control. Learning how to self-regulate.	431	of cross over with things like anger
Normalising through comparisons to other addictions.	432	management, emotion regulation, maybe
	433	thinking about the effect of drugs. That would
	434	cross both groups, but I would envisage in the
Adapting tried and tested treatments.	435	specific sex offending group you would focus
	436	on something like the Finklehor model like I
	437	explained. So going in detail about the stages
Not hiding away from fantasy. Addressing the wishes of the	438	of offending, you would probably have
client.	439	something focused on sexual fantasies that
	440	you probably wouldn't have in a more general
Developing compassion.	441	group. Erm, you would probably also, maybe
	442	include things like victim empathy type
	443	issues. Yeah that is kind of what I think will be
Placing an emphasis on behaviours and thoughts linked to	444	the key components that are actually different
offending. Adding specificity to treatments.	445	between the two groups where you target
	446	more things that are offence related. And
Exploring every nook and cranny. No hiding from the reality	447	probably in the sex offending group if you like
of their desire.	448	what we do currently, and what is needed, is
	449	for people to talk through their offence
Requiring a challenging attitude by therapists.	450	individually in a bit more detail. Usually
	451	lasting one or two sessions, and that gives us
	452	a chance to formulate the offence and maybe
Looking to solve the problem.	453	challenge and ask questions. That probably
	454	would be so relevant to a general
	455	relationships type group that would focus

	456 457 458 459 460 461 462	more on yeah like I said problem solving, social skills, attitudes towards women – that is sort of the key issue – regulating emotions, dealing with jealousy. The more sorts of general things. So I think that is where we heading, and that sort of reflects these types of services more generally.
	463 464	I: So is it more a psycho-educational group? Going through what is OK and what is not?
Placing social norms in line with legal guidelines. Treatment requires acceptance. Acknowledging the unspeakable. Normalising to all. Breaking down barriers and isolation. Needing to deny due to shame. Avoiding the presence of their thoughts. Needing to break the cycle between thinking and doing. Acknowledgement as an uphill battle. Needing to break down barriers to speaking. Enjoying the thrill of confession.	465 466 467 468 469 470 471 472 473 474 475 476 477 478 479 480 481 482	P: Erm, not so much. I guess what is not OK is what is illegal really, but fantasies involving violence and sex are highly problematic. The biggest thing is just trying to get people to admit that they have sexual fantasies which is you know mad, because *everyone in the world does have some sort of sexual fantasies*. But you sort of ask the question, "How many of you have sexual fantasies?" And you will get, "well I have never had one", kind of responses. So it normalising that as something, and trying to get people to acknowledge this other idea that when you commit an offence is it often because you have rehearsed it in your mind and fantasised about it many, many times. And that can be one of the steps towards offending. it is quite hard to get people to acknowledge that, and

	483	even to get people to talk about their
	484	fantasies in a group is incredibly difficult. You
Revelling in an audience.	485	get the odd one or two who want to do it, and
	486	often get off on it, which is another problem
Removing the stigma to improve self-understanding.	487	really because they are too open and are
	488	maybe psychopathic and want to excite a
Educating on warning signs.	489	group by talking about explicit fantasies. But I
	490	guess, you know, the general aim would be to
	491	normalise it – this is what happens, this is the
	492	way that increases your risk if you are
Reconditioning as a tempting treatment tool.	493	fantasising. Particularly these may be
Impossibility of asking people to be reconditioned.	494	problematic fantasies if you are fantasising
Limitations of humanity.	495	about children which is problematic, or rape
	496	fantasies those kinds of things. I guess, there
Educating on the cycles of offending. Pre-empting the next	497	used to be whole movement about almost
steps.	498	reconditioning them in regards to having
	499	appropriate fantasies and that is the basis of
	500	inappropriate fantasies and that is kind of
Masturbation as a tool to self-management.	501	almost impossible really to ask people to do
Stepping away from sexual gratification as an acceptable	502	really. But its just getting the idea about if you
management tool.	503	are having inappropriate fantasies and using
	504	that, that is very reinforcing and could lead to
Acknowledging limits of therapy. Therapists facing an uphill	505	your risk increasing but if you can manage
battle. Therapy as unsuccessful.	506	that, because often people use sex or
	507	masturbation those kinds of things as a way
Intensity the key to success?	508	to manage difficult feelings, so if you can
	509	manage them in a different way that doesn't
Lacking motivation a pitfall to success.	510	involve inappropriate legal fantasies then that
	511	is going to help in the long run. So it is that

	512 513 514 515 516 517 518 519	general thing. How successful we are, *we are not that successful*. I wonder how successful other people are? Maybe the more specific sexual offending services such as those in prison might be more intense in that area, but we are dealing with a group where motivation is an issue, so even getting them to think about it can be a challenge actually.
	520 521 522	I: It sounds like normalising could be alluding to a safety to disclose? Feeling like they would be understood rather than rebuffed?
Encouraging a safety to talk. Building a community of support and safety. Needing honesty to decrease risk. Therapists being blind-sided. Honesty allows for the sharing of responsibility. Placing trust in others to help overcome fantasies.	523 524 525 526 527 528 529 530 531 532 533 534 535 536 537	P: Yeah, I think so. Because ultimately what you want them to do is to disclose to their team who are going to be looking out for them and if they are keeping it to themselves – "I have never had a fantasy ever" – that is not so helping in terms of managing their risk because you don't know what is going on. Whereas if you can say to their supervising person in the community, "look I am having a few fantasies and I am struggling with this", that is really good because at least you can have a much more open dialogue, what you can do and how to manage it, those sorts of things. So yeah, hopefully that is the first step really, to acknowledge it.

	538 539	I: And have you found groups to be more successful than individual therapeutic work?
Focusing on normalisation. Peers unequivocally better in the treatment of clients. Watching mistakes happen in groups, unavoidable truths Group dynamics normalise that urges will return. Groups lacking individuality. Discussing the pros and cons of group vs individual. Key to success is combination treatments. Funding promotes the use of groups. Treatments determined through finances rather than benefits.	540 541 542 543 544 545 546 547 548 549 550 551 552 553 554 555 556 557 558 559 560 561 562 563 564	P: I think so, I think so because I think – I am a big fan of groups generally, and we run all kinds of groups here – but I think that the normalising aspect that you don't get in individual work, I think you don't get the peer challenge that I spoke about in individual work. I think those are the real sort of key things, and I think *you also see people slip up* and you can learn from each other. So there is quite a lot of support, and you can kind of learn ok they seem to be ok and then they have relapsed and are being recalled – I think that is a powerful message. Obviously you lose a lot because it is a broad-brush approach, but we do try and do individual formulations. You are talking generally about attitudes or fantasies and in individual work you can really target those. So maybe a *combination is the best way to work* with that scenario. Yeah, you want the general group processes to help but you also want to target and I guess there is the whole efficient way to do it. And the limits of resources that results in it needing to be cost-effective but yeah I am a big fan of groups in that sense.

	565	I: You can target a wider amount of people.
Not connecting with all clients. Not trusting impressions. Holding scepticism. Keeping themselves protected. Hiding a hidden reality. Contrasting client presentations (heterogeneous). Activating self-indulgency, revelling in sexual indulgence, voyeuristic pleasures from group engagement? Groups providing clarity. Being reared against the norm (nurture), deciphering a correct upbringing. Imposing a standard. "wrong kind of way" Clients imposing social standards, ability to adhere to some social norms. Becoming distracted through dialogue. Colluding in a hidden truth. Being removed from role of professional. Being controlled by client. Acting in a game? Putting on a false self. Therapist feeling like a fraud.	566 567 568 569 570 571 572 573 574 575 576 577 578 579 580 581 582	P: Yeah, very much so. And you can have people who you know, you will have someone who you are not sure about .You will have someone for example who is quite guarded and then you will have someone else there who is very strong, open, hedonistic attitudes and it kind of draws out the attitudes of that person, you get a clearer idea just because it has kind of almost been *normalised in the wrong kind of way*. So you get a lot more information some times. Or they will say, "no you can't say that", and I guess you kind of end up talking about many different things rather than sometimes sitting as a professional and it feels, it feels kind of phoney in some ways when you say, "lets talk about your fantasy".
	583 584	I: They know you don't fully understand in the way that a peer would understand?
Lacking a sense of believability, unconvincing in the role of therapist. Drawn into incompetency. Doubting ability to counsel. Having to hold back. Distancing oneself from opinion. Needing to leave behind attitudes, becoming a blank slate.	585 586 587 588 589 590	P: I think so, I think that there is credibility from their peers. And it is quite hard to not be drawn into that role. You know you cant be judgemental as a therapist, but I guess you are quickly drawn into, particular if it is, it is quite hard to leave all those attitudes at the

Transforming all into offenders. Personalising the offence. Unable to escape impact of harrowing details, needing to shut off thoughts. Dismissing actions. Needing to step away from automatic reactions, slowing down own thoughts, avoiding accusations. Monitoring and muting self as therapist. Therapists needing to incorporate self-control. Mimicking struggle with impulsivity. Diluting struggle in groups, groups as a therapists defence strategy.	591 592 593 594 595 596 597 598 599 600 601 602 603 604	door. If there is a child sex offender sat in front of you talking about how they invited someone knocking on their door into the house, and then locked them in and abused them – that is someone I have worked with – to kind of not think about you know, and they are saying "well it just kind of happened". You know, to not say and to jump in and say, "Did you plan this? It looks like this is something you wanted to happen". Sometimes it is quite hard to step back from that thing that you want to do, and there is probably less of that in a group potentially due to being able to open up the discussion a bit more.
	605 606	I: It seems more about responsibility taking rather than challenging?
 Wanting to dismiss blame. Generalising to all. Blame and punishment, forcing a stance of accountability. Reiterating, stressing importance, repeated assaults of blame? Monotonous stance. Safety in repetition. Therapy becoming a chore. Trudging over similar ground. Feeling judged/on show. Denying risk of actions. Attempting to step away from past.	607 608 609 610 611 612 613 614 615 616 617 618	P: Yeah, that is the key thing actually. Responsibility is really hard for *people* to take on. And, yeah it might just feel a bit punishing; in terms of long-term work I have done individually. So every week meeting with the individual and talking about sexual offending and some people really value it, but for some it can be like 'oh god again', they have the psychologist sitting with them and they are talking about their offence again and it feels, particularly if they minimise things or "this is in the past, I am never going to do this again"

Pushing the point. Not allowing avoidance. Reiterating risk. Therapist as abuser. Attempting to justify stance. Needing to believe in what you're doing.	619 620 621 622 623	and then I am hammering home well lets just think about what happened or – it can feel punishing I suppose in some ways. But it is the work they probably need to do in order to get out.
	624 625 626 627	I: And is there a difference between the perceptions of their urges and fantasies as to whether it forms part of their sexuality or is an addiction?
"addiction is an interesting word". Forming bridges between addiction and urges. Society shaming minority. Externalising blame as rarity. "your proper paedophile". Subtypes of classification. Moving away from stereotype perception. Falling into trouble Attempting to justify actions, making it relatable. Clients refraining from addiction, using a separate discourse, not blaming addition. Refraining from externalising blame. Avoiding responsibility rather than re-attributing. Happening upon trouble. Excusing through loss of inhibitions.	628 629 630 631 632 633 634 634 635 636 637 638 639 640 641 642 643 644	P: *Addiction is an interesting word*. Yeah there is a lot of similarities I guess between working with addictions and these kinds of urges. There is not many people at work, maybe one or two, who say you know, "*I'm attracted to children, there is nothing wrong with it, society is wrong for saying this culture doesn't allow it", you know that is kind of minority – your proper paedophile* I suppose. Most other people it is just, "I just found myself in that situation…she was only 15…", you know those kinds of excuses. And *they don't usually talk about it in kind of addictive or addiction terms* such as they couldn't or "I just couldn't stop myself". But often it is, it sort of not wanting to take responsibility for their actions, "I just found myself in that situation", "I was just a bit drunk", those kinds

Difference between client and prof: modelling on addiction, reframing treatment modalities. Addiction allows for seeing the person aside from the behaviour, removing the stigma from treatment, treating like an addict not an offender. Adding a generalisability/normality to working treatment examples.	645 646 647 648 649 650 651 652 653 654 655	of things. But *I think an addiction model* is actually very useful, as in addiction models you often think of high-risk situations and core beliefs that support it or seeming irrelevant decisions that lead up to an offence. So usually it is quite a good model and seems less stigmatising really, "if you start to think about how does an alcoholic find themselves in the pub having a few drinks, you know, so there might be some similarities to how you offended".
	656 657 658 659	I: Relating it to an alcoholic going to the pub sounds more hopeful than if it is a sexuality that cannot be changed? It provides more optimism too?
Therapists required to bring the hope. Needing to believe in hope/change. Can only work if you believe, needing to put your faith in treatment A monster on the loose. A socially determined fright. Socially determined opinions. Monstrous other. An untreatable danger. Labelled for life. Classified amongst the worst. Removing the continuum.	660 661 662 663 664 665 666 667 668 669 670 671	P: Yeah, and I guess *we have to be optimistic*. And I am a firm believer that people can change – *I wouldn't be here if I didn't believe* that. I was working somewhere where, it was a weird guy – obviously a healthcare professional – I can't remember who he was, but he said in the car park, *"oh a paedophile has got out",* or something like that. So there is obviously strong feelings that paedophiles are this evil and they can't change, *once a sex offender always a sex offender*, and you kind of hear those things banded about. But they are

Therapy becoming a business transaction. A funding dependant system. An operational procedure. Believing in the treatment. Witnessing change. Witnessing success builds motivation. No lost cause, inspiring hope for change, learning to live with yourself. Fighting against the social stigma, swimming against the social tide, Society baying for blood, wishing for death	672 673 674 675 676 677 678 679 680 681 682 683 684	really unhelpful, because I guess *we are in the business of helping people to change*, manage their behaviour or manage their risk really. And *we can do that; I have seen that, I have seen it be successful*. And I think just thinking that just because you may have deviant fantasies towards children, even if they don't go away doesn't mean you can't change or recover. But you are *fighting against society* who thinks often the opposite really, you know, *paedophiles should be shot* or something like that which is horrible. It is a common view point.
	685 686 687	I: And is there something about that social stigma that prevents them from openly discussing this as an open discourse?
Classified as offenders, segregated from the general population. Acknowledging the vulnerability of labelling. Separating for protection. Professionals equally to blame. Inescapable stigma by prof. no escaping demonising world view. Acting out despite role of power. Silencing. Remaining mute for safety.	688 689 690 691 692 693 694 695 696 697 698	P: Yeah, I would say I think you know it is so stigmatising. And often they have been in prison where they have been on the sex offender's wing or vulnerable prisoners wing, something like that. Yeah people treat them differently, a child sexual offender – for all our professionalism – there are many members of staff that will judge them very negatively and maybe act that out some how, where that is implicit. They have probably learnt to keep that fairly quiet, you know you will get beat

Fearing for safety. Being defamed. Society capitalising on derogatory language. Fearing judgement, blending into normality, concealing truth/identity, maintaining the secret. Damaging high profile cases, increasing need to hide. Tsunami of trouble, baying for blood. Lumping all together, blurring boundaries, treating the same. Society controlled through media, educating by example. Informing with lies, a misled society, blinded by stories. Moving away from traditional perception, keeping it in the family. No stranger danger. Holding incorrect assumptions. Wrongful expectation. Misled picture. Learning from lies. Building a deceptive picture. Having to defend position. Fighting against pressure to punish. Defamed by society. Wider public perception. A majority view. Generalising public opinion, lumping together. Defending choice to help, defending need for treatment. Whose definition of better? Living in line with society. Increasing complexity, protecting individual and society, unable to see individual aside from public. Reframing decision to help. Making decision socially	699 700 701 702 703 704 705 706 707 708 709 710 711 712 713 714 715 716 717 718 719 720 721 722 723 724 725 726 727	up if you are a 'nonce' of whatever it is in prison. Yeah and I suppose, there are many negative judgements so they do try and hide and keep it under wraps because the whole Operation Yewtree and Jimmy Saville has brought it even more the fore. This is an outing and a crusade against any potential sort of sex offender, so you know; they are not immune to that. And I think the media is very influential towards that, I think it is very misdirected in many ways because most sex offenders offend against members of their family, it isn't this stranger out their and the Jimmy Saville types who you keep an eye out for – the dirty old men around the parks. Sometimes it is that, but I think there is lots of these misinformed stories that influence us unfortunately. And often I get asked *'how can you work with a sex offender?"* you know, "you are helping these people, that is out of order" and I guess that is what people, a lot of people who view this offence say. It is just I guess the general attitude, and I respond by saying, "I do generally think they need help, *they should be helped to live a better life*", you know we are dealing with the most complex people, but above that we have the whole public protection side of things. I am not just helping them, I am helping potential victims to not get

acceptable. Justifying choices.	728 729	abused so that the easier way to look at it, a more therapeutic way.
	730 731 732 733 734 735 736	I: As you said quite honestly, that if someone does disclose – especially in this environment - it does have a very real impact upon how and when they are discharged. So is there something about the way society is currently set up that puts the public first and the individual second?
A consequence fearing society, avoiding rather than dealing. Distinguishing between subtypes, but all offenders. Blowing up in media, making waves with risk Shunning prospect of risk, altering attitudes in fear. Saving own skin. Questioning self, doubting judgements, pushing decisions on to others, distancing association. Having to protect yourself. Prioritising self. Classifying risk, determining consequences, Fearing public retribution, fearing making the wrong call. Continually being questioned, having to answer to the public.	737 738 739 740 741 742 743 744 745 746 747 748 749 750 751 752 753 754	P: Yeah, I think so. Yeah I think we are quite risk adverse. And it can be that way, in this service and mainly we do have violent offenders rather than risk offenders but there has been a few things recently where it has hit the headlines, the local press or there has been something risky and quite quickly you see the culture change a bit. Do you really want people to have leave? You have to think twice because *do you want the scrutiny*? Do you want an investigation? *Do you want your reputation, or more likely your job on the line*? And its kind of a big overriding factor of how to take the positive risks, and you know, I guess we all try and do that but *it is quite easy to feel quite scared I think.* Particularly when people say, "how could you do that?" There was this one guy, and obviously it is

Making own classifications. Therapist making labels. Being imprisoned for other offences. Moving between systems, progressing in treatment, being passed between professionals. Escaping the system, running to freedom, returning to past dangers, recreating risk. Bashing public trust, no escaping media scrutiny. Tarnishing all with the actions of one, acting with panic, enforcing boundaries. Lacking spectrum of urges to behaviours. Higher powers taking control, professionals fearing consequences. Being banished from treatment. Querying offers of help. Distancing by professionals, discriminating against the many because of the few. No escape, hunted down, tracing and tracking. Creating a universal approach. Reducing professional risk, avoiding damage, discriminating help. Every man for himself. Service before the individual. Only client group to cause damage? Needing expertise to help, feeling duty bound to help,	755 756 757 758 759 760 761 762 763 764 765 766 767 768 769 770 771 772 773 774 775 776 777 778 779 780 781 782 783	confidential, who is, who I would class as a paedophile. So very strong fantasies towards children, and his index offence was quite nasty involving the false imprisonment of a young child and he was in high secure, but he is on one of the wards here. And last year, he managed to use his leave and run away and get involved in another very risky similar situation and I think it hit the headlines, and he was quite high profile anyway. So very quickly if you have this kind of thing happen you are going to clamp down on, and I was asked personally to revisit the pathway for sex offenders generally, which was part when I talked about redesigning the groups. Well what was behind it from the service director was the question, and he didn't explicitly say this but what he means was – *should we be accepting sex offenders*? Or should we be tagging - we have this thing now where we tag very high profile offenders which is controversial – should we tag all sex offenders? Which are sort of very risk adverse type practices, because I guess the thinking behind it is that *if we don't admit sex offenders then we cant get our fingers burnt really*. And quite clearly what came out of these meetings was that we should definitely accept sex offenders because we have the expertise to

playing to strengths. Moving against society, determining own standards. Prioritising ethics over morals. Facing organisational pressures, bureaucracy leaking in. Pressures to deny treatment, pressures to conform to social loathing. One shot saloon, treading a fine line. Collusion between press and police. Circulating fear within society. Playing catch-up to public fear, fighting an uphill battle. Always a step behind. Dealing with knock on fears. Questioning all on the basis of one. Fear permeates all. Fear overrules mind.	784 785 786 787 788 789 790 791 792 793 794 795 796 797 798 799 800 801 802 803 804 805 806 807 808	work with these individuals and *we shouldn't let public opinion or local politicians dictate how we work clinically*. But you can see how particularly senior people in the service have a lot of pressure on them to do things differently. And you know, all it takes is for one slip up. Even if nothing goes wrong, it takes maybe a high profile person to abscond – and we have quite a few absconding as many services do. So say someone absconds and comes back 4 hours later after going to their parent's house, something like that, it is very low risk pretty much. But if that gets known, as sometimes the police know and they will circulate that to the press, then suddenly you are on the back foot. We don't want that to happen again because what we don't want it to have another offence, and then the pressure builds up and it seeps downwards I think. It makes all people on the wards think should I let this guy out on leave? He has been a bit dodgy, should I be a bit more strict? It is those kinds of things that permeate everything.
	809 810 811 812	I: It sounds like a two way thing, it is very difficult for them to trust professionals, but as professional it is also difficult to trust what is being said due to external pressures.

Maintaining an air of scepticism. Doubting the client, questioning the existence of truth/trust. Finding a double life, being kept in the dark. Ability to bury truth, hiding a reality. Questioning the therapeutic relationship. Accepting therapist limitations, acknowledging the presence of the unknown. Striving for perfection, dealing with continued disappointment. Ridding from society, denying existence, expulsion from reality. Needing to take a stance, fighting for belief.	813 814 815 816 817 818 819 820 821 822 823 824 825 826 827 828 829 830 831 832	P: Yeah, exactly. And you know, *can you ever really trust what is said*? You may think it is fine and then you find out, and I have had incidents where you find out they have gone on leave for a year – and this wasn't a sex offender but – he had been in a relationship with someone and she was about to give birth. And we didn't even know he was in a relationship, and his index offence related to a violent offence against a woman, you think someone can hide stuff that is significant for quite long periods of time. You do start to think, how much do you know? And you can't know everything, you have to accept that there is limitations – but *the public wouldn't accept that*. *If you let someone out and they offend against a child, then they should be locked up forever*. They ask, "how could you let someone like that out?" *You have to fight against the tide.*
	833 834 835	I: I get a sense of needing to learn limitations, both for the potential offenders but also for the professionals who are willing to help?
	836 837 838	P: We try and manage the risks as best we can but we can't lock people up forever. There are some services you can, high secure hospitals

Aspiring for freedom. Going against the public desire. Establishing risk from offenders. Being asked to do too much, pulled from all angles. Distributions of blame unequal, therapists more accountable than prosecutors. Competency determined by recidivism. Being held accountable, pressures to deliver change.	839 840 841 842 843 844 845 846 847 848 849 850 851 852 853 854 855 856	with high-risk individuals but in a medium or low secure unit *we don't want to lock people up forever*. We want people to move on with their lives and we want to manage it as best we can. But we know that risks increase and people reoffend, things like that. I think we are given a bit of a difficult remit in secure services, health services, that is someone reoffends or gets recalled it feels like there is some sort of blame. You know, what did we do wrong? *If they reoffend then we didn't do our job well enough* or we released them too early. But prisons you don't get that. They serve their sentences, they could go out and reoffend the same day and get called back but no one says, "how come you didn't make sure they didn't reoffend?" So there is more pressure on the forensic services.
	857 858 859	I: And my final question is, is there anything else you feel should or could be offered to this client group that could be beneficial?
Lacking expertise as a field, not equipped to offer help. Honing skills to add specificity.	860 861 862 863 864 865	P: Specifically to people with child sex offending? Erm, I don't think we are set up very well in services to really target child sex offenders. You know, I think we have a lot of skills, and as psychologists we can work individually or work with groups, but as I said

Requiring individual approaches. Being forwarded on, making appropriate referrals, calling for the creation of specific services. Wishing to improve, chastising options available. Requiring interest, specificity and likeminded individuals. Introducing chemical boundaries. Removing nature. Needing to determine if nature or nurture. Impacting the offers of help, lacking genuine empathy and a	866 867 868 869 870 871 872 873 874 875 876 877 878 879 880 881 882 883 884 885 886 887 888 889 890 891 892 893 894	I think the groups are a mix of child and adult sex offenders – *it is a bit of a heterogeneous bunch*. I think if people get better here, from their illness, and they are not psychotic and they can manage on their medication – I think they should be sent to somewhere where it is very specific expertise to work with child sex offenders. So it might be a prison setting, or it might be someone else I'm not sure, but *I think we could do better in terms of the treatment they get*. If they are in a group of 10 child sex offenders who very much focus on that, and you have got people who work primarily with that client group, I think they would get better treatment to be honest. So maybe we could do that better. There *has been talk about anti-libidinal medication*, I don't know enough about it. It is obviously very controversial. It might help a couple of individuals particularly if it is the urge, and it is their sex drive that is driving any offending, I think maybe that could be considered. I don't think we maybe have the expertise on that, where as high secure places such as Broadmoor have quite a few I think, or a handful but still not many. So I think that, that is another area that could be thought about potentially. Erm, I think we probably need, because we don't have that many, *we have a*

wish to help. Changing professional training, equipping practitioners. Maintaining the standards of counselling psychology, holding the values of therapy, treating with care.	895 896 897 898 900 901 902 903 904 905 906 907 908	*lack of understanding and a social stigma*, we probably need more training in terms of working with people who are child sex offenders. And understanding it because I don't think there is any, particularly ward based stuff, that when they get one maybe it is, there is a lot of misunderstanding and maybe to have more routine training and facts behind it, and early background understanding I think could be helpful in *having a compassionate approach* towards these individuals. Those are the sort of things that stand out I think.
	909	I: Ok, well thank you for your time.

	1 2 3 4 5 6	I: As you are aware this research is interested in sexual thoughts, feelings and fantasies people might have towards children, and I'm guessing as you have agreed to take part in this research you have some experience of working with such individuals.
	7	P: Yeah
	8	I: So for me to understand what it is you will

	9 10 11	be sharing today, I was wondering if you could tell me about the context and experience that you have.
Progressing, working way up Working with both sides of the coin Working with the wider context, seeing beyond the offence Returning to the field Displaying loyalty to the field Sex offending infiltrates all areas Distinguishing CSO from other offenders Distinguishing fantasy from offending, yet classifying as similar. Lumping together. Blurring categorisation. Defining expertise. Blurring the lines between CSO and paedophilic thoughts Differing treatments to the needs of the job/client Needing to determine risk.	12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36	P: So, I have worked in forensic settings starting as an assistant psychologist starting in 1999 or something like that. I worked with people who were sex offenders, or child sex offenders at that time. As an assistant psychologist I did individual client work, which maybe wasn't offence related specifically, at that time. Probably after that there wasn't much contact for a few years, and then when I got my doctorate I worked in the JH* centre which was in this trust, in about 2003, and I have been working in forensics ever since. Always there is some sex offenders in teams in which I work, not always child sexual offenders or people with those kind of fantasies. But I have worked with a few individually, I have run at least two or three sexual offender behaviour treatment programmes which have included child sex offenders, or people from that background, plus *lots of allegation type of individuals* or you know those kind of things. So I have done individual therapy, some long term, some shorter term and some groups. I have done a lot of risk assessments, and specific sex

CSO missing from NHS forensic wards. CSO missing from treatment.	37 38 39 40 41 42 43 44	offender risk assessments for those individuals. Yeah that is the kind of context, so probably all in all you are talking around 12-13 years of being in these kinds of settings. But you know for example I haven't worked with a child sex offender for a couple of years *just because there haven't been any on my ward.*
	45 46	I: And is there a specific way of working with this client group that you use?
Placing trust in CBT practices. Therapists needing to be flexible Accommodating for complexity Altering thoughts to meet client demands. Exploring the thoughts of the client. Using approaches designed for offenders Hoping for the best, learning by trial and error, a confusing patchwork treatment	47 48 49 50 51 52 53 54 55 56 57 58 59 60 61	P: Probably if anything it would be CBT. We have to be fairly integrative because we have people with severe mental health difficulties and this is the rehabilitation part where there are primary difficulties. Therefore we have had to think slightly integratively but we are guided by CBT principles so we could be looking at cognitions related to offending, looking at specific models such as the Finklehor model or Good Lives Model which is thought about more commonly now. So there are various things out there and we try and *have a bit of a mish-mash* and put it together, but probably CBT is the main approach for us.
	62	I: So the main focus of this part of the

	63 64 65 66 67 68	research, will focus on those who there may be allegations but they haven't been convicted. And I was wondering how that might come up in therapy, is that something they would broach or is it something you are already made aware of?
Offending thoughts never hidden Clients being influenced by hospital setting, needing to escape. Disclosing as a barrier to freedom. Feeling constricted by consequences. Clients acting similarly (more homogenous than thought?) Entering the system through guises. Working with offenders is more common. Allegations treated the same as conviction. Disclosing once in trouble.	69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87	P: I am trying to think whether, I can't think of any examples where it hasn't been known but then had come out in a therapeutic session. Given the setting, *every one wants to get out*, or I think every one wants to get out, so *disclosing that sort of information is only going to stall things for them*. So I think they are fairly aware that they are not really going to disclose that, and for most people it follows a bit of a pattern. So some people will have come in for some kind of sexual offence, or some kind of conviction, so typically we would be working with somebody who has some kind of charge or conviction, or if there are allegations. Sometimes new information does come out, they will say there is also this other thing or something similar but it is not usually new information. I can't think of an example where that has happened.
	88 89	I: So normally it has come out during previous treatment? And it would be provided to you

	90	on a risk assessment?
Needing pre-warning of the client, learning about the client not from the client Being passed from service to service Not trusting the client, going beyond what clients are willing to say, finding out the dirt. Understanding risk as paramount. Data collection as initial response to treatment. Having nothing to work with.	91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110	P: Yeah, so when people are admitted to either here or the JH*, usually the JH*, *we receive a pack* and usually in there is their offence history or their charges, or their conviction. Sometimes there is a risk assessment if they have been somewhere else, sometimes it is their first time at a psychiatric service so you get a bit of information. Especially if they are at the acute end you have to *do a bit more digging* to find out things, you might sort of revisit a lot of the court depositions where they are talking about the offence, you would probably want a proper full on risk assessment initially. So you would asking around and gathering information when they arrive at a secure hospital, something like that. You are trying to get as much as possible but it generally builds up over time. Sometimes you are not given a lot information actually.
	111 112 113 114 115	I: And this is something you would, as an organisation, would directly broach with the client? If it was written on a risk assessment? Is it something you make explicit with them that you are aware of?

No hiding from the truth, leading with honesty with clients. Services needing to improve management of risk. Striving for better. Adjusting to social need. Disclosing prior knowledge of clients, sharing the evidence, setting out action plans/conditions that need to be met. Seeing refusals as denial rather than innocence, clients displaying distortions of thought.	116 117 118 119 120 121 122 123 124 125 126 127 128	P: Yeah I think so. I think we are definitely guided by transparency really in terms of risk. And we have made loads of improvements in terms of how risk is managed here, we have risk groups and so on. And even kind of before that, we would be saying we know what your index offence is, or what your conviction is, and you need to do some work on this in order to move on. So yeah I think we would be pretty upfront about that. They might not want to hear it, *or they might want to deny it or will want to minimise it*, but that is always the starting point.
	129 130 131 132 133	I: The focus I guess, what they might find useful, beneficial or protective in order to help them not act upon their thoughts, urges or fantasies. Is there anything you have found in this form of work that is beneficial?
	134 135	P: Erm, what do you mean? Therapeutic approaches?
	136	I: Anything really?
Protecting through confinement, helping through custody. Removing options. Removing access, stopping behaviours through removing choice. Building a fantasy treatment scenario – removing	137 138 139 140 141	P: Erm well I think on the basic level *sometimes a period of confinement or being in a secure hospital is helpful* you know. They don't have access to victims, potential victims, obviously no children are allowed in here. So I

from reality. Removing freedom to act. Battling thoughts without access to behave. Protecting children is fundamental to treatment. Separating potential offenders from potential victims. Segregation as protective to all. Increasing risk throughout treatment. Pushing limits, "testing people out", pushing trust, expecting failure? Own training influences factors deemed helpful. Distinguishing opinion from other professionals. Managing risk through therapy. Needing to understand likelihood of offending. Risk determines all. Moving beyond CSO, blurring lines in classification. Seeing paedophilia/hebephilia as an illness. Attitudes like an addiction. An addiction of the mind. Exploring the role fantasy plays. Breaking down the meaning of fantasy life. Extending work from offending to CSO. Moulding into one. Classifying as CSO. Following ideas rather than evidence. A guessing game?	142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170	think a period of time where they are not able to have that sort of access or you know, battle with those urges potentially is very beneficial in the first instinct. So I think that is quite practical because you know, many offend against children in their own family. So having that sort of separation is a very useful first step, so then you can begin to build up the risks by take a few more risky things. So giving people leave and *testing people out*, and those kind of things really help and yeah are beneficial. I think therapeutic approach, and I speak as a psychologist, is what we think is a huge part of managing the risk really. So it is about understanding the risk behind their offending, understanding their triggers and things like there is a lot of overlap with other kinds of offending, but it is about understanding their illness, understanding their drug use, understanding their attitudes towards children or with other offenders it is others. Understanding their fantasies and I guess you know, sometimes, I think that Finklehor model, I don't know if you know it very well but it is the steps to sexual offending model, and it applies to child sexual offending. So it is this *idea* that there is various steps you have to do in order to

Acting on impulse. Being overpowered from within. Fragmenting the steps to acting. The desire to act. "You have to have the intention" – the difference between offenders and non? Facing peers as a greater aide to treatment, facing peers rather than an alien professional. Challenging oneself through others. Funding impacting treatment, removing of speciality and specificity. Reluctant to engage publically. Stigmatising occurring in treatment, bullying by other sex offenders, distinguishing as vulnerable, bottom of the pecking line. Alleviating fear of isolating, "you are not alone" building hopes, creating a community. Overwhelming shame from facing stigma. Silencing shame. Needing to break down rationalisations. Peers as judge and jury. Removing the option of denial/avoidance. Having to face the truth. Confronting a mirror image rather than a distorted reflection.	171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198	offend. It is actually quite helpful for service users, and use when they say, "it was in the moment, I couldn't help it". And when you break it down, there is these sort of four steps, *you have to have the intention*, you have to overcome internal inhibitors as well as external things, and have motivation – those kinds of things. So actually breaking it down in that way is actually quite helpful. Erm peer support and peer challenge I think is helpful. So you know, in groups we run, we often have mixed groups – adult sex offenders and child sex offenders often in the same group. Mainly because of numbers, we can't get enough numbers to fill up a group. And that has its own advantages because sometimes child sex offenders get quite stigmatised within that sex offending group actually. But on a sort of more general scale, normalising it and saying you know, *"you are not alone"*, because there are these huge amounts of shame and guilt. And you know getting challenged, "I was just doing this", the minimisations that occur – a member of the group will say things that hold them to account. And that is powerful, much more powerful than when a professional would do that. So that is kind of really helpful.

	199 200	I: It makes it more real for them if it is from a peer rather than a professional?
Voice of a professional lacking impact. Preaching tones form an unintentional barrier to change. Alienating clients through wording. Confronting with powerful reality. Using peers to confront distortions. Wanting for clients to experience truth. Professionals will always be on the outside? Using the power of peer, removing social difference as a barrier to reality. Looking beyond what the client can do for themselves. Needing to build community connections, extending the boundaries of treatment, sharing knowledge between professionals as paramount to managing risk. Releasing with boundaries. Removing *ability* to offend rather than tackling *want*.	201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223 224 225 226	P: Yeah, I think so because they probably all have experienced professionals saying, well you know we don't mean to, but it can sound a bit preachy and drab when we say, "you should take responsibility for this, that and the other. But if you have someone else who has also committed a sexual offence say, "when you walk down the street and found yourself chatting to that child for example, did you not sort of plan that a little bit? Were you not going down that street because you knew you would bump into someone?", you know and just having that, it hits home rather than us saying "no, no, you are just being negative when you think like that". I think that is a very powerful intervention. Beyond that I think a lot of the work we do is just to build up really good external controls, so some change and some don't. It is trying to have a really supportive community team for when they move on, who are fully aware of their risks and we can sort of prevent access to victims potentially. Through very strict monitoring and involvement with community services that is really helpful as well as it stops them from offending.

	227 228 229	I: So when you say external controls, could you give an example of something that might be put in place?
Using risk to exclude individuals from society. Imposing barriers and rules. Connecting services together. Reporting to agencies as standard. Removing privacy. Breaching anonymity as a strategy to reduce risk to children.	230 231 232 233 234 235 236 237 238 239 240	P: Erm sometimes some geographical areas are restricted so *you are not allowed to* enter a particular borough or a particular postcode. Particularly if there is a specific victim, such as a family member or something like that, so that reduces the risk greatly. It could also be informing the governing bodies like MAPPA and having them in discussions, or the police in *knowing where the individual lives* I think is also really useful. So those kinds of things, making sure it is planned really.
	241 242	I: And can those exclusions be self-exclusions or would they be imposed upon them?
Making decisions for the client. Not risking harm to the public. Making impositions. No escaping imposed boundaries. Facing consequences for their actions. Gifting the clients with their release. Signing up to a	243 244 245 246 247 248 249 250 251	P: They are often imposed, yeah. So yeah often you have conditions of discharge where it says you are not allowed to enter that borough, or go within 500m of the family home – something like that. And if you are found to breach that then you can potentially get recalled or put back on, if it a prison sentence, call backed effectively. So yeah often it is built into the *package*.

discharge programme. A business deal?		
	252 253 254	I: And how do they find that? Do they find it safer because those restrictions are put in place?
Enforcing actions despite disapproval. Going against the wishes of clients. Justifying constraints placed on clients. Safety in lack of options. Needing a lack of options. Guessing what is useful for clients. Anger inducing constrictions.	255 256 257 258 259 260 261 262 263 264 265 266	P: Erm, I think they often resent it. Particularly if they are – it depends how much insight they have got – some individuals think it is useful for them because you know particularly if they feel they are struggling with urges to offend and they think well I cant get anywhere near my children. They might think that is quite helpful, but there is plenty who would think that that 'you are just being restrictive and there is no need for me to not go there, it is out of order'. So it is a mixed bag really.
	267 268 269	I: And would you say those who are more accepting have a potential to do better in regards to abstaining from their urges?
Insight as the key to change. Learning from factors associated with sex offenders. Applying knowledge to a different client group. Lacking acceptance of impulses as a risk factor for	270 271 272 273 274 275 276	P: I think so yeah. I think insight is quite a key thing. I did some training last week on stable and acute risk assessment, I don't know if you know it? It for sex offenders and they have got these particular factors that are very much associated with the risk of them reoffending. And I don't know why I mentioned that, but

offending. Providing insight is beneficial in therapy. Associating ambivalence with offending. Needing help from others, going beyond the means of the client. Using restrictions to contain concerns. Alleviating fear through boundaries. Learning from past vulnerabilities. Learning from the client.	277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293	thinking about their risk factors in terms of those who are more accepting is very much to do with those who see sort of their urges and impulsivities as a big factor and have an insight into that. So yeah I do think they find that useful. There is one guy who I have been working with for example, offended against his children or his stepchildren and he – I think he was quite ambivalent. On the one hand he would say he couldn't help himself and he kind of minimised it a bit, but on the other hand I think there is something quite containing about knowing he couldn't have any access to his children. Given that it has been problematic in the past. So I think on the whole for him, it was actually quite helpful and he found it helpful.
	294 295 296 297 298	I: So I am guessing that if you don't necessarily don't approve of what you are doing, having that restriction could be safety inducing? Knowing you wont go over your own boundary?
Holding the client through constriction.	299	P: It can be very containing, I think yeah.
	300 301	I: And they have discussed the importance of family dynamics in helping them to abstain?

Sex offenders as a minority client group. Stemming from dysfunctional homes. Developing outside the social norm. Shaping through shared experiences. Lacking stability and safety as a childhood risk factor. Fighting on their own. Dysfunctional support worse than no support? Families blurring the lines between social norms. Growing up in a different 'norm'. Dysfunctional family norms causing irreparable damage to individuals. Restricting access to damaging normalities. Removing previous family norms. Needing to isolate individuals, stopping the cycle. Lacking evidence for family support as helpful.	302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322 323 324 325	P: Erm, I am just trying to think. It is quite hard. People who are child sex offenders, and I mean there isn't loads in this service, when I think about their families – it has been quite dysfunctional. Often they may have been abused themselves as a child and I often think there is quite a disintegrated sort of family. So, just the ones who come to mind are, they have had very little family access and support. And when there has been access or support it has been quite problematic so there is a guy on one of the wards here who offended against his own daughter, and there is a whole culture in that family of very unclear boundaries and sex between family members, things like that. And the family is actually very destructive for him, when he has contact with them it is destructive and it really sets him back and stresses him out. We try and restrict that quite a lot. I can't, no examples come to mind where a family has been really supportive for those with child sexual offences. Adult sex offenders there is a bit more evidence of that.
	326 327 328 329	I: I guess that might be the difference between someone who hasn't acted and is seeking help, in comparison to someone who has crossed that line?

Attempting to work with ideals. Wanting the client to want to change. Telling the client what they want. Taking ownership with the client. Creating a joint responsibility. Educating social sexual norms. Challenging moving forward. Dealing with more than the offending urges. Continually being tested as a therapist. Needing to go above the client. Looking externally rather than internally. Containment as the professional preference. Distinguishing mental health patients from offenders. CSO as developmental, nurture rather than nature. Changing behaviour to be left alone. Behaviour holds the key to escaping? Facing limitations within organisations. Needing extensive support, requiring more than can be given. No overcoming the problem. Fruitless aim of help?	330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357	P: Yeah, ideally. Yeah I mean you know, ideally for these guys you would say, "lets think about it, *you want to* work on your boundaries and relationships and *we need to* really think about what is appropriate and inappropriate sexual relationships". But often is quite difficult to get beyond that, you have very chronic people especially here in the rehab setting where boundary issues are constantly at play. On the ward they are getting tested out with staff and yeah sometimes they can get it a bit more and can be a little bit more self-contained but often it doesn't quite get there and you have to think about external containment really. That is the ideal, but I think we have got a different kind of client group compared to maybe sexual offenders in prison who are maybe more high functioning or feel like they slipped up. But here it is often born out of more chronic behaviours and difficult upbringing. But yeah that would be the ideal and altering those behaviours so they can kind of just get on with it. Yeah recidivism is quite high in terms of child sex offenders, it is something that in a setting it is hard to sort of reduce those rates. You know, with a lot of therapy and a lot of input you can reduce it. There is a lot of

	358 359 360 361 362	research showing that, but not by huge amounts. So it is kind of this group where you think it is always going to be a bit of an issue, particularly if they have got deviant fantasies and things like that.
	363 364	I: And more so if they have added difficulties on the side, such as mental health difficulties?
Facing a multitude of difficulties. Going beyond the scope of specific services. Mental health difficulties adds fuel to an already uncontrollable fire. Living outside of reality, building their own norms. Nature taking over.	365 366 367 368 369 370 371 372 373 374	P: Hmm yeah, exactly. We are dealing with a lot of co-morbidity problems. So chronic schizophrenia, or personality disorder, just sorts of complicates the picture a whole lot more. And sometimes the offending is based upon delusional thinking, and sometimes it is based on sort of pure sex offending type attitudes. Sometimes it is to do with their personality, so yeah it does get a bit more complicated, very complicated actually.
	375 376 377 378	I: And have you noticed from working within the different settings that there is a different approach that is required to work with this client group?
Needing to rework treatments. Classifying all as sexual offenders. Generalising the clients. Grouping all together due to	379 380 382 382	P: Erm, well we have just been reviewing our pathways for sex offenders here actually. What we felt is there is probably a need for, because typically we have had a sex offender

structural difficulties. Working with limitations. Lacking a desire to engage. Willingness to accept help not present in all. Asking for commitment from clients. Clients being forced to wait. Dealing with constraints to get help. Services unequipped to offer support. Lacking immediate access to help fuels risk? Lacking suitable definitions, searching for acceptable catagorisations. Going beyond sex offending, needing to explore relationships in a wider context. Building a programme to suit the needs of the presenting clients. Dealing with allegations. Classifying the severity of the behaviour to determine treatment.	383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399 400 401 402 403 404 405 406 407 408 409 410 411	treatment programme that is kind of for all sex offenders with a conviction and it has been quite hard to get enough numbers. Even though we are quite a large service the number of people willing to engage in that is actually quite small so you can kind of typically start a group with 8 or 9 people. It is quite a long group, just over a year of weekly sessions, and sometimes it takes a good year to get on the waitlist before you can start the group. So we thought what we probably need is to revisit it. There is probably a sub group that, I don't know how define them, but high-risk sex offenders, where sex offending is their main, they main issue – their main problem if you like. So targeting that with a specific sex offending group. But we have a lot more patients who have difficulties with relationships more generally, so that might be expressed with, we have got quite a few people where it is alleged that they have raped someone or have committed another sexual offence, or are very sexually inappropriate on the wards with staff – maybe lower level offences such as exposure. Or more general relationship difficulties such as domestic violence problems and I guess what we thought is that there is a need for a group to look at more general relationships

Changing the services offered to clients. Moving to a unified approach.	412 413 414 415 416 417 418 419 420	and tackle lower level sex offending type behaviours. And I think that is where we are heading actually, and other sexual offending services do something a bit similar. So like a relationships type group, tackling low level plus domestic violence and relationships and then maybe a sort of more hard core group which you might see more of in high secure settings.
	421 422	I: And would that be increased in frequency, or more focussed in content?
Improving ability to engage in societally accepted ways. Educating social norms. Challenging and reframing attitudes. Teaching self-control. Learning how to self-regulate. Normalising through comparisons to other addictions. Adapting tried and tested treatments. Not hiding away from fantasy. Addressing the wishes of the	423 424 425 426 427 428 429 430 431 432 433 434 435 436 437 438	P: Erm, I think it would be different content. So I would envisage the relationships to be a bit more general and maybe focussing on social skills type interventions. Maybe thinking about attitudes a lot, that is relevant to both groups. And think about the generalisable skills, because we do quite a few different groups where we think there is a lot of cross over with things like anger management, emotion regulation, maybe thinking about the effect of drugs. That would cross both groups, but I would envisage in the specific sex offending group you would focus on something like the Finklehor model like I explained. So going in detail about the stages of offending, you would probably have

client. Developing compassion. Placing an emphasis on behaviours and thoughts linked to offending. Adding specificity to treatments. Exploring every nook and cranny. No hiding from the reality of their desire. Requiring a challenging attitude by therapists. Looking to solve the problem.	439 440 441 442 443 444 445 446 447 448 449 450 451 452 453 454 455 456 457 458 459 460 461 462	something focused on sexual fantasies that you probably wouldn't have in a more general group. Erm, you would probably also, maybe include things like victim empathy type issues. Yeah that is kind of what I think will be the key components that are actually different between the two groups where you target more things that are offence related. And probably in the sex offending group if you like what we do currently, and what is needed, is for people to talk through their offence individually in a bit more detail. Usually lasting one or two sessions, and that gives us a chance to formulate the offence and maybe challenge and ask questions. That probably would be so relevant to a general relationships type group that would focus more on yeah like I said problem solving, social skills, attitudes towards women – that is sort of the key issue – regulating emotions, dealing with jealousy. The more sorts of general things. So I think that is where we heading, and that sort of reflects these types of services more generally.
	463 464	I: So is it more a psycho-educational group? Going through what is OK and what is not?
Placing social norms in line with legal guidelines.	465	P: Erm, not so much. I guess what is not OK is

	466	what is illegal really, but fantasies involving
Treatment requires acceptance. Acknowledging the	467	violence and sex are highly problematic. The
unspeakable.	468	biggest thing is just trying to get people to
Normalising to all. Breaking down barriers and isolation.	469	admit that they have sexual fantasies which is
	470	you know mad, because *everyone in the world*
	471	*does have some sort of sexual fantasies*. But
Needing to deny due to shame. Avoiding the presence of	472	you sort of ask the question, "How many of
their thoughts.	473	you have sexual fantasies?" And you will get,
	474	"well I have never had one", kind of
	475	responses. So it normalising that as
	476	something, and trying to get people to
Needing to break the cycle between thinking and doing.	477	acknowledge this other idea that when you
	478	commit an offence is it often because you
Acknowledgement as an uphill battle.	479	have rehearsed it in your mind and fantasised
Needing to break down barriers to speaking.	480	about it many, many times. And that can be
	481	one of the steps towards offending. it is quite
Enjoying the thrill of confession.	482	hard to get people to acknowledge that, and
	483	even to get people to talk about their
	484	fantasies in a group is incredibly difficult. You
Revelling in an audience.	485	get the odd one or two who want to do it, and
	486	often get off on it, which is another problem
Removing the stigma to improve self-understanding.	487	really because they are too open and are
	488	maybe psychopathic and want to excite a
Educating on warning signs.	489	group by talking about explicit fantasies. But I
	490	guess, you know, the general aim would be to
	491	normalise it – this is what happens, this is the
	492	way that increases your risk if you are
Reconditioning as a tempting treatment tool.	493	fantasising. Particularly these may be
Impossibility of asking people to be reconditioned.	494	problematic fantasies if you are fantasising

Limitations of humanity. Educating on the cycles of offending. Pre-empting the next steps. Masturbation as a tool to self-management. Stepping away from sexual gratification as an acceptable management tool. Acknowledging limits of therapy. Therapists facing an uphill battle. Therapy as unsuccessful. Intensity the key to success? Lacking motivation a pitfall to success.	495 496 497 498 499 500 501 502 503 504 505 506 507 508 509 510 511 512 513 514 515 516 517 518 519	about children which is problematic, or rape fantasies those kinds of things. I guess, there used to be whole movement about almost reconditioning them in regards to having appropriate fantasies and that is the basis of inappropriate fantasies and that is kind of almost impossible really to ask people to do really. But its just getting the idea about if you are having inappropriate fantasies and using that, that is very reinforcing and could lead to your risk increasing but if you can manage that, because often people use sex or masturbation those kinds of things as a way to manage difficult feelings, so if you can manage them in a different way that doesn't involve inappropriate legal fantasies then that is going to help in the long run. So it is that general thing. How successful we are, *we are not that successful*. I wonder how successful other people are? Maybe the more specific sexual offending services such as those in prison might be more intense in that area, but we are dealing with a group where motivation is an issue, so even getting them to think about it can be a challenge actually.
	520 521 522	I: It sounds like normalising could be alluding to a safety to disclose? Feeling like they would be understood rather than rebuffed?

Encouraging a safety to talk. Building a community of support and safety. Needing honesty to decrease risk. Therapists being blind-sided. Honesty allows for the sharing of responsibility. Placing trust in others to help overcome fantasies.	523 524 525 526 527 528 529 530 531 532 533 534 535 536 537	P: Yeah, I think so. Because ultimately what you want them to do is to disclose to their team who are going to be looking out for them and if they are keeping it to themselves – "I have never had a fantasy ever" – that is not so helping in terms of managing their risk because you don't know what is going on. Whereas if you can say to their supervising person in the community, "look I am having a few fantasies and I am struggling with this", that is really good because at least you can have a much more open dialogue, what you can do and how to manage it, those sorts of things. So yeah, hopefully that is the first step really, to acknowledge it.
	538 539	I: And have you found groups to be more successful than individual therapeutic work?
Focusing on normalisation. Peers unequivocally better in the treatment of clients. Watching mistakes happen in groups, unavoidable truths Group dynamics normalise that urges will return.	540 541 542 543 544 545 546 547 548	P: I think so, I think so because I think – I am a big fan of groups generally, and we run all kinds of groups here – but I think that the normalising aspect that you don't get in individual work, I think you don't get the peer challenge that I spoke about in individual work. I think those are the real sort of key things, and I think *you also see people slip up* and you can learn from each other. So there is

Groups lacking individuality. Discussing the pros and cons of group vs individual. Key to success is combination treatments. Funding promotes the use of groups. Treatments determined through finances rather than benefits.	549 550 551 552 553 554 555 556 557 558 559 560 561 562 563 564	quite a lot of support, and you can kind of learn ok they seem to be ok and then they have relapsed and are being recalled – I think that is a powerful message. Obviously you lose a lot because it is a broad-brush approach, but we do try and do individual formulations. You are talking generally about attitudes or fantasies and in individual work you can really target those. So maybe a *combination is the best way to work* with that scenario. Yeah, you want the general group processes to help but you also want to target and I guess there is the whole efficient way to do it. And the limits of resources that results in it needing to be cost-effective but yeah I am a big fan of groups in that sense.
	565	I: You can target a wider amount of people.
Not connecting with all clients. Not trusting impressions. Holding scepticism. Keeping themselves protected. Hiding a hidden reality. Contrasting client presentations (heterogeneous). Activating self-indulgency, revelling in sexual indulgence, voyeuristic pleasures from group engagement? Groups providing clarity. Being reared against the norm (nurture), deciphering a correct upbringing. Imposing a standard. "wrong kind of	566 567 568 569 570 571 572 573 574 575	P: Yeah, very much so. And you can have people who you know, you will have someone who you are not sure about .You will have someone for example who is quite guarded and then you will have someone else there who is very strong, open, hedonistic attitudes and it kind of draws out the attitudes of that person, you get a clearer idea just because it has kind of almost been *normalised in the wrong kind of way*. So you get a lot more

way" Clients imposing social standards, ability to adhere to some social norms. Becoming distracted through dialogue. Colluding in a hidden truth. Being removed from role of professional. Being controlled by client. Acting in a game? Putting on a false self. Therapist feeling like a fraud.	576 577 578 579 580 581 582	information some times. Or they will say, "no you can't say that", and I guess you kind of end up talking about many different things rather than sometimes sitting as a professional and it feels, it feels kind of phoney in some ways when you say, "lets talk about your fantasy".
	583 584	I: They know you don't fully understand in the way that a peer would understand?
Lacking a sense of believability, unconvincing in the role of therapist. Drawn into incompetency. Doubting ability to counsel. Having to hold back. Distancing oneself from opinion. Needing to leave behind attitudes, becoming a blank slate. Transforming all into offenders. Personalising the offence. Unable to escape impact of harrowing details, needing to shut off thoughts. Dismissing actions. Needing to step away from automatic reactions, slowing down own thoughts, avoiding accusations. Monitoring and muting self as therapist. Therapists needing to incorporate self-control. Mimicking struggle with impulsivity.	585 586 587 588 589 590 591 592 593 594 595 596 597 598 599 600 601 602	P: I think so, I think that there is credibility from their peers. And it is quite hard to not be drawn into that role. You know you cant be judgemental as a therapist, but I guess you are quickly drawn into, particular if it is, it is quite hard to leave all those attitudes at the door. If there is a child sex offender sat in front of you talking about how they invited someone knocking on their door into the house, and then locked them in and abused them – that is someone I have worked with – to kind of not think about you know, and they are saying "well it just kind of happened". You know, to not say and to jump in and say, "Did you plan this? It looks like this is something you wanted to happen". Sometimes it is quite hard to step back from that thing that you want to do, and there is probably less of that

Diluting struggle in groups, groups as a therapists defence strategy.	603 604	in a group potentially due to being able to open up the discussion a bit more.
	605 606	I: It seems more about responsibility taking rather than challenging?
Wanting to dismiss blame. Generalising to all. Blame and punishment, forcing a stance of accountability. Reiterating, stressing importance, repeated assaults of blame? Monotonous stance. Safety in repetition. Therapy becoming a chore. Trudging over similar ground. Feeling judged/on show. Denying risk of actions. Attempting to step away from past. Pushing the point. Not allowing avoidance. Reiterating risk. Therapist as abuser. Attempting to justify stance. Needing to believe in what you're doing.	607 608 609 610 611 612 613 614 615 616 617 618 619 620 621 622 623	P: Yeah, that is the key thing actually. Responsibility is really hard for *people* to take on. And, yeah it might just feel a bit punishing; in terms of long-term work I have done individually. So every week meeting with the individual and talking about sexual offending and some people really value it, but for some it can be like 'oh god again', they have the psychologist sitting with them and they are talking about their offence again and it feels, particularly if they minimise things or "this is in the past, I am never going to do this again" and then I am hammering home well lets just think about what happened or – it can feel punishing I suppose in some ways. But it is the work they probably need to do in order to get out.
	624 625 626 627	I: And is there a difference between the perceptions of their urges and fantasies as to whether it forms part of their sexuality or is an addiction?
"addiction is an interesting word".	628	P: *Addiction is an interesting word*. Yeah there

Forming bridges between addiction and urges. Society shaming minority. Externalising blame as rarity. "your proper paedophile". Subtypes of classification. Moving away from stereotype perception. Falling into trouble Attempting to justify actions, making it relatable. Clients refraining from addiction, using a separate discourse, not blaming addition. Refraining from externalising blame. Avoiding responsibility rather than re-attributing. Happening upon trouble. Excusing through loss of inhibitions. Difference between client and prof: modelling on addiction, reframing treatment modalities. Addiction allows for seeing the person aside from the behaviour, removing the stigma from treatment, treating like an addict not an offender. Adding a generalisability/normality to working treatment examples.	629 630 631 632 633 634 634 635 636 637 638 639 640 641 642 643 644 645 646 647 648 649 650 651 652 653 654 655	is a lot of similarities I guess between working with addictions and these kinds of urges. There is not many people at work, maybe one or two, who say you know, "*I'm attracted to children, there is nothing wrong with it, society is wrong for saying this culture doesn't allow it", you know that is kind of minority – your proper paedophile* I suppose. Most other people it is just, "I just found myself in that situation…she was only 15…", you know those kinds of excuses. And *they don't usually talk about it in kind of addictive or addiction terms* such as they couldn't or "I just couldn't stop myself". But often it is, it sort of not wanting to take responsibility for their actions, "I just found myself in that situation", "I was just a bit drunk", those kinds of things. But *I think an addiction model* is actually very useful, as in addiction models you often think of high-risk situations and core beliefs that support it or seeming irrelevant decisions that lead up to an offence. So usually it is quite a good model and seems less stigmatising really, "if you start to think about how does an alcoholic find themselves in the pub having a few drinks, you know, so there might be some similarities to how you offended".

	656 657 658 659	I: Relating it to an alcoholic going to the pub sounds more hopeful than if it is a sexuality that cannot be changed? It provides more optimism too?
Therapists required to bring the hope. Needing to believe in hope/change. Can only work if you believe, needing to put your faith in treatment A monster on the loose. A socially determined fright. Socially determined opinions. Monstrous other. An untreatable danger. Labelled for life. Classified amongst the worst. Removing the continuum. Therapy becoming a business transaction. A funding dependant system. An operational procedure. Believing in the treatment. Witnessing change. Witnessing success builds motivation. No lost cause, inspiring hope for change, learning to live with yourself. Fighting against the social stigma, swimming against the social tide, Society baying for blood, wishing for death	660 661 662 663 664 665 666 667 668 669 670 671 672 673 674 675 676 677 678 679 680 681 682 683	P: Yeah, and I guess *we have to be optimistic*. And I am a firm believer that people can change – *I wouldn't be here if I didn't believe* that. I was working somewhere where, it was a weird guy – obviously a healthcare professional – I can't remember who he was, but he said in the car park, *"oh a paedophile has got out",* or something like that. So there is obviously strong feelings that paedophiles are this evil and they can't change, *once a sex offender always a sex offender*, and you kind of hear those things banded about. But they are really unhelpful, because I guess *we are in the business of helping people to change*, manage their behaviour or manage their risk really. And *we can do that; I have seen that, I have seen it be successful*. And I think just thinking that just because you may have deviant fantasies towards children, even if they don't go away doesn't mean you can't change or recover. But you are *fighting against society* who thinks often the opposite really, you know, *paedophiles should be shot* or something like that which is horrible. It is a

	684	common view point.
	685 686 687	I: And is there something about that social stigma that prevents them from openly discussing this as an open discourse?
Classified as offenders, segregated from the general population. Acknowledging the vulnerability of labelling. Separating for protection. Professionals equally to blame. Inescapable stigma by prof. no escaping demonising world view. Acting out despite role of power. Silencing. Remaining mute for safety. Fearing for safety. Being defamed. Society capitalising on derogatory language. Fearing judgement, blending into normality, concealing truth/identity, maintaining the secret. Damaging high profile cases, increasing need to hide. Tsunami of trouble, baying for blood. Lumping all together, blurring boundaries, treating the same. Society controlled through media, educating by example. Informing with lies, a misled society, blinded by stories. Moving away from traditional perception, keeping it in the	688 689 690 691 692 693 694 695 696 697 698 699 700 701 702 703 704 705 706 707 708 709 710	P: Yeah, I would say I think you know it is so stigmatising. And often they have been in prison where they have been on the sex offender's wing or vulnerable prisoners wing, something like that. Yeah people treat them differently, a child sexual offender – for all our professionalism – there are many members of staff that will judge them very negatively and maybe act that out some how, where that is implicit. They have probably learnt to keep that fairly quiet, you know you will get beat up if you are a 'nonce' of whatever it is in prison. Yeah and I suppose, there are many negative judgements so they do try and hide and keep it under wraps because the whole Operation Yewtree and Jimmy Saville has brought it even more the fore. This is an outing and a crusade against any potential sort of sex offender, so you know; they are not immune to that. And I think the media is very influential towards that, I think it is very misdirected in many ways because most sex offenders offend against members of their

family. No stranger danger. Holding incorrect assumptions. Wrongful expectation. Misled picture. Learning from lies. Building a deceptive picture. Having to defend position. Fighting against pressure to punish. Defamed by society. Wider public perception. A majority view. Generalising public opinion, lumping together. Defending choice to help, defending need for treatment. Whose definition of better? Living in line with society. Increasing complexity, protecting individual and society, unable to see individual aside from public. Reframing decision to help. Making decision socially acceptable. Justifying choices.	711 712 713 714 715 716 717 718 719 720 721 722 723 724 725 726 727 728 729	family, it isn't this stranger out their and the Jimmy Saville types who you keep an eye out for – the dirty old men around the parks. Sometimes it is that, but I think there is lots of these misinformed stories that influence us unfortunately. And often I get asked *'how can you work with a sex offender?"* you know, "you are helping these people, that is out of order" and I guess that is what people, a lot of people who view this offence say. It is just I guess the general attitude, and I respond by saying, "I do generally think they need help, *they should be helped to live a better life*", you know we are dealing with the most complex people, but above that we have the whole public protection side of things. I am not just helping them, I am helping potential victims to not get abused so that the easier way to look at it, a more therapeutic way.
	730 731 732 733 734 735 736	I: As you said quite honestly, that if someone does disclose – especially in this environment - it does have a very real impact upon how and when they are discharged. So is there something about the way society is currently set up that puts the public first and the individual second?
	737	P: Yeah, I think so. Yeah I think we are quite

A consequence fearing society, avoiding rather than dealing.	738	risk adverse. And it can be that way, in this
	739	service and mainly we do have violent
Distinguishing between subtypes, but all offenders.	740	offenders rather than risk offenders but there
	741	has been a few things recently where it has
Blowing up in media, making waves with risk	742	hit the headlines, the local press or there has
	743	been something risky and quite quickly you
Shunning prospect of risk, altering attitudes in fear. Saving	744	see the culture change a bit. Do you really
own skin.	745	want people to have leave? You have to think
Questioning self, doubting judgements, pushing decisions	746	twice because *do you want the scrutiny*? Do
on to others, distancing association.	747	you want an investigation? *Do you want your*
Having to protect yourself. Prioritising self.	748	*reputation, or more likely your job on the line*?
	749	And its kind of a big overriding factor of how
Classifying risk, determining consequences,	750	to take the positive risks, and you know, I
	751	guess we all try and do that but *it is quite easy*
Fearing public retribution, fearing making the wrong call.	752	*to feel quite scared I think.* Particularly when
Continually being questioned, having to answer to the	753	people say, “how could you do that?” There
public.	754	was this one guy, and obviously it is
Making own classifications. Therapist making labels.	755	confidential, who is, who I would class as a
	756	paedophile. So very strong fantasies towards
Being imprisoned for other offences.	757	children, and his index offence was quite
	758	nasty involving the false imprisonment of a
Moving between systems, progressing in treatment, being	759	young child and he was in high secure, but he
passed between professionals.	760	is on one of the wards here. And last year, he
Escaping the system, running to freedom, returning to past	761	managed to use his leave and run away and
dangers, recreating risk.	762	get involved in another very risky similar
Bashing public trust, no escaping media scrutiny.	763	situation and I think it hit the headlines, and
	764	he was quite high profile anyway. So very
	765	quickly if you have this kind of thing happen
Tarnishing all with the actions of one, acting with panic,	766	you are going to clamp down on, and I was

enforcing boundaries. Lacking spectrum of urges to behaviours. Higher powers taking control, professionals fearing consequences. Being banished from treatment. Querying offers of help. Distancing by professionals, discriminating against the many because of the few. No escape, hunted down, tracing and tracking. Creating a universal approach. Reducing professional risk, avoiding damage, discriminating help. Every man for himself. Service before the individual. Only client group to cause damage? Needing expertise to help, feeling duty bound to help, playing to strengths. Moving against society, determining own standards. Prioritising ethics over morals. Facing organisational pressures, bureaucracy leaking in. Pressures to deny treatment, pressures to conform to social loathing. One shot saloon, treading a fine line.	767 768 769 770 771 772 773 774 775 776 777 778 779 780 781 782 783 784 785 786 787 788 789 790 791 792 793 794 795	asked personally to revisit the pathway for sex offenders generally, which was part when I talked about redesigning the groups. Well what was behind it from the service director was the question, and he didn't explicitly say this but what he means was – *should we be accepting sex offenders*? Or should we be tagging - we have this thing now where we tag very high profile offenders which is controversial – should we tag all sex offenders? Which are sort of very risk adverse type practices, because I guess the thinking behind it is that *if we don't admit sex offenders then we cant get our fingers burnt really*. And quite clearly what came out of these meetings was that we should definitely accept sex offenders because we have the expertise to work with these individuals and *we shouldn't let public opinion or local politicians dictate how we work clinically*. But you can see how particularly senior people in the service have a lot of pressure on them to do things differently. And you know, all it takes is for one slip up. Even if nothing goes wrong, it takes maybe a high profile person to abscond – and we have quite a few absconding as many services do. So say someone absconds and comes back 4 hours later after going to their parent's house, something like that, it is

Collusion between press and police. Circulating fear within society. Playing catch-up to public fear, fighting an uphill battle. Always a step behind. Dealing with knock on fears. Questioning all on the basis of one. Fear permeates all. Fear overrules mind.	796 797 798 799 800 801 802 803 804 805 806 807 808	very low risk pretty much. But if that gets known, as sometimes the police know and they will circulate that to the press, then suddenly you are on the back foot. We don't want that to happen again because what we don't want it to have another offence, and then the pressure builds up and it seeps downwards I think. It makes all people on the wards think should I let this guy out on leave? He has been a bit dodgy, should I be a bit more strict? It is those kinds of things that permeate everything.
Maintaining an air of scepticism. Doubting the client, questioning the existence of truth/trust. Finding a double life, being kept in the dark. Ability to bury truth, hiding a reality.	809 810 811 812 813 814 815 816 817 818 819 820 821 822 823	I: It sounds like a two way thing, it is very difficult for them to trust professionals, but as professional it is also difficult to trust what is being said due to external pressures. P: Yeah, exactly. And you know, *can you ever really trust what is said*? You may think it is fine and then you find out, and I have had incidents where you find out they have gone on leave for a year – and this wasn't a sex offender but – he had been in a relationship with someone and she was about to give birth. And we didn't even know he was in a relationship, and his index offence related to a violent offence against a woman, you think someone can hide stuff that is significant for

Questioning the therapeutic relationship. Accepting therapist limitations, acknowledging the presence of the unknown. Striving for perfection, dealing with continued disappointment. Ridding from society, denying existence, expulsion from reality. Needing to take a stance, fighting for belief.	824 825 826 827 828 829 830 831 832	quite long periods of time. You do start to think, how much do you know? And you can't know everything, you have to accept that there is limitations – but *the public wouldn't accept that*. *If you let someone out and they offend against a child, then they should be locked up forever*. They ask, "how could you let someone like that out?" *You have to fight against the tide.*
	833 834 835	I: I get a sense of needing to learn limitations, both for the potential offenders but also for the professionals who are willing to help?
Aspiring for freedom. Going against the public desire. Establishing risk from offenders. Being asked to do too much, pulled from all angles. Distributions of blame unequal, therapists more accountable than prosecutors. Competency determined by recidivism.	836 837 838 839 840 841 842 843 844 845 846 847 848 849 850	P: We try and manage the risks as best we can but we can't lock people up forever. There are some services you can, high secure hospitals with high-risk individuals but in a medium or low secure unit *we don't want to lock people up forever*. We want people to move on with their lives and we want to manage it as best we can. But we know that risks increase and people reoffend, things like that. I think we are given a bit of a difficult remit in secure services, health services, that is someone reoffends or gets recalled it feels like there is some sort of blame. You know, what did we do wrong? *If they reoffend then we didn't do our job well enough* or we released them too

Being held accountable, pressures to deliver change.	851 852 853 854 855 856	early. But prisons you don't get that. They serve their sentences, they could go out and reoffend the same day and get called back but no one says, "how come you didn't make sure they didn't reoffend?" So there is more pressure on the forensic services.
	857 858 859	I: And my final question is, is there anything else you feel should or could be offered to this client group that could be beneficial?
Lacking expertise as a field, not equipped to offer help. Honing skills to add specificity. Requiring individual approaches. Being forwarded on, making appropriate referrals, calling for the creation of specific services. Wishing to improve, chastising options available.	860 861 862 863 864 865 866 867 868 869 870 871 872 873 874 875 876 877	P: Specifically to people with child sex offending? Erm, I don't think we are set up very well in services to really target child sex offenders. You know, I think we have a lot of skills, and as psychologists we can work individually or work with groups, but as I said I think the groups are a mix of child and adult sex offenders – *it is a bit of a heterogeneous bunch*. I think if people get better here, from their illness, and they are not psychotic and they can manage on their medication – I think they should be sent to somewhere where it is very specific expertise to work with child sex offenders. So it might be a prison setting, or it might be someone else I'm not sure, but *I think we could do better in terms of the treatment they get*. If they are in a group of 10 child sex offenders who very much focus on

Requiring interest, specificity and likeminded individuals.	878 879 880 881	that, and you have got people who work primarily with that client group, I think they would get better treatment to be honest. So maybe we could do that better. There *has*
Introducing chemical boundaries. Removing nature.	882 883 884	*been talk about anti-libidinal medication*, I don't know enough about it. It is obviously very controversial. It might help a couple of
Needing to determine if nature or nurture.	885 886 887 888 889 890 891 892 893	individuals particularly if it is the urge, and it is their sex drive that is driving any offending, I think maybe that could be considered. I don't think we maybe have the expertise on that, where as high secure places such as Broadmoor have quite a few I think, or a handful but still not many. So I think that, that is another area that could be thought about potentially. Erm, I think we probably need,
Impacting the offers of help, lacking genuine empathy and a wish to help. Changing professional training, equipping practitioners.	894 895 896 897 898 900 901 902 903 904 905	because we don't have that many, *we have a* *lack of understanding and a social stigma*, we probably need more training in terms of working with people who are child sex offenders. And understanding it because I don't think there is any, particularly ward based stuff, that when they get one maybe it is, there is a lot of misunderstanding and maybe to have more routine training and facts behind it, and early background understanding I think could be helpful in
Maintaining the standards of counselling psychology, holding the values of therapy, treating with care.	906 907	*having a compassionate approach* towards these individuals. Those are the sort of things

	908	that stand out I think.
	909	I: Ok, well thank you for your time.

Appendix 21: **Example of focused codes from the interview with "Oliver"**

	134 135	P: Erm, what do you mean? Therapeutic approaches?
	136	I: Anything really?
Protecting through confinement Removing freedom to act Segregation as protective to all. Managing risk through therapy.	137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159	P: Erm well I think on the basic level *sometimes a period of confinement or being in a secure hospital is helpful* you know. They don't have access to victims, potential victims, obviously no children are allowed in here. So I think a period of time where they are not able to have that sort of access or you know, battle with those urges potentially is very beneficial in the first instinct. So I think that is quite practical because you know, many offend against children in their own family. So having that sort of separation is a very useful first step, so then you can begin to build up the risks by take a few more risky things. So giving people leave and *testing people out*, and those kind of things really help and yeah are beneficial. I think therapeutic approach, and I speak as a psychologist, is what we think is a huge part of managing the risk really. So it is about understanding the risk behind their offending, understanding their triggers and things like there is a lot of overlap with other

	160	kinds of offending, but it is about
	161	understanding their illness, understanding
An addiction of the mind.	162	their drug use, understanding their attitudes
	163	towards children or with other offenders it is
	164	others. Understanding their fantasies and I
	165	guess you know, sometimes, I think that
	166	Finklehor model, I don't know if you know it
	167	very well but it is the steps to sexual
Moulding into one.	168	offending model, and it applies to child sexual
A guessing game?	169	offending. So it is this *idea* that there is
	170	various steps you have to do in order to
	171	offend. It is actually quite helpful for service
	172	users, and use when they say, "it was in the
	173	moment, I couldn't help it". And when you
	174	break it down, there is these sort of four
	175	steps, *you have to have the intention*, you have
	176	to overcome internal inhibitors as well as
	177	external things, and have motivation – those
	178	kinds of things. So actually breaking it down
	179	in that way is actually quite helpful.
Facing peers rather than an alien professional.	180	Erm peer support and peer challenge I think
	181	is helpful. So you know, in groups we run, we
	182	often have mixed groups – adult sex offenders
	183	and child sex offenders often in the same
	184	group. Mainly because of numbers, we can't
	185	get enough numbers to fill up a group. And
	186	that has its own advantages because
	187	sometimes child sex offenders get quite
Bottom of the pecking line.	188	stigmatised within that sex offending group

	189	actually. But on a sort of more general scale,
"you are not alone"	190	normalising it and saying you know, *"you are*
	191	*not alone"*, because there are these huge
Silencing shame.	192	amounts of shame and guilt. And you know
	193	getting challenged, "I was just doing this", the
	194	minimisations that occur – a member of the
Peers as judge and jury.	195	group will say things that hold them to
	196	account. And that is powerful, much more
	197	powerful than when a professional would do
	198	that. So that is kind of really helpful.